MAY-JUNE, 1955

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

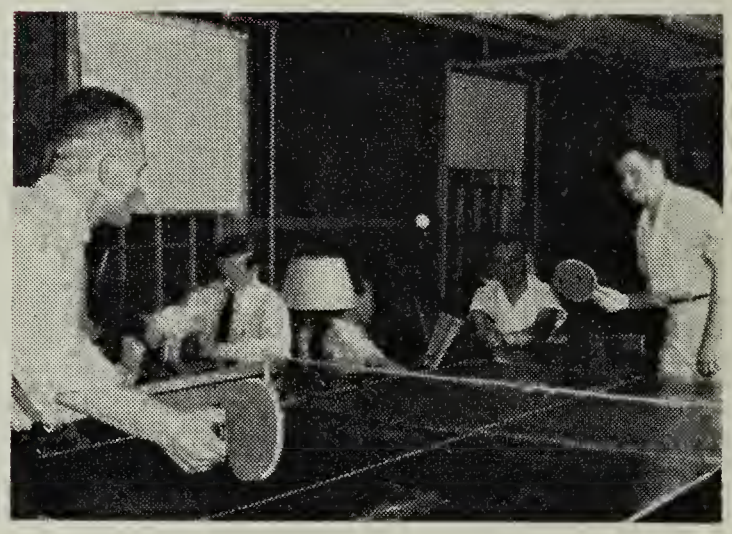
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME V — NUMBER 1

MAY-JUNE, 1955

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

ARP Education Material

Thanks very much for your fine assistance in providing materials for us to use in our unit of work on alcohol. We have approximately 270 students in this program and are delighted with the good work our teachers are doing.

Bert Ishee, Principal
Alexander Graham Junior High School
Fayetteville, N. C.

Alcoholics' Needs

I have enjoyed the splendid articles in the recent issues of INVENTORY. Your portrayal of the alcoholic's needs is most human and heartwarming.

A. C.
Holly Springs, N. C.

Word Gets Around

We have heard several good speakers remarking about the INVENTORY that you publish, and we would like very much to have copies sent to us.

Secretary
Bessemer AA Group
Greensboro, N. C.

New Hope

Please place my name on your mailing list for INVENTORY. To me the publication is an especially fine one and it has offered new hope to me for a promise of possible recovery for my brother.

Name Withheld

Chaplain Uses Inventory

If my name is still on your mailing list, please notice my new address. I thoroughly enjoyed INVENTORY while in the civilian parish. Now that I am in the military chaplaincy, I find need for such constructive information as INVENTORY provides. Thank you for this effective publication.

Warren Turner, Chaplain
2nd Marine Division, FMF
Camp Lejuene, N. C.

AA Likes Articles

INVENTORY is an excellent magazine and in my opinion is the best of its type in the field. Your publications have meant a great deal to us members of AA and we look forward to reading them.

Miss B. W.

Objective Study

I am enrolled in Duke Divinity School and hold a student appointment. I would like to be placed on your subscription list to INVENTORY. The program in which you are engaged is very worthwhile to those of us who deal with the problem objectively as well as to those who conquer their alcohol problem with your aid.

Rev. Al R. Knotts, Jr.
Durham, N. C.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

A GLANCE at our calendar reveals an unusually heavy schedule of activities for the ARP during the spring and summer months.

In scheduling two additional summer schools for teachers this year, we are placing upon our staff a considerable work load. Beginning June 7, when the course at East Carolina College convenes, until the middle of July with the conclusion of the session at Appalachian, Summer Studies on Facts About Alcohol will be running continuously, with several of the sessions overlapping. This necessitates a checkerboard pattern of travel for our personnel who are lecturing at these schools, not to mention the work which goes into the preparation and presentation of the lectures.

We were aware that this tight schedule would face us, however, when we set up our summer schools. Upon calculating our extra effort against the potential educational value of adding two more courses, we decided that it would be well worthwhile. We do hope that teachers in the state are going to respond by attending Summer Studies on Facts About Alcohol in large numbers. I am sure that our teachers do not have to be reminded of their responsibility to convey accurate and objective facts about alcohol to their young students in the classroom. Nor are they unaware of their very important role in the prevention of alcoholism. Our summer study courses are intended primarily to help the teacher do a more adequate job in these two essential areas.

Another important event in which some of our staff will participate is the Kanuga Conference on Alcoholism, sponsored by the Episcopal Diocese of North Carolina. Dates for this conference are June 10-12 at the Episcopal summer assembly ground in Hendersonville, N. C. Dr. Kelly, Miss Lytle, and I are honored to have a part on the program, along with Dr. John Ewing, psychiatrist at N. C. Memorial Hospital, Rev. Ernest Shepherd, Director of the Florida Alcoholic Rehabilitation Program, and Rev. Joel Kellerman, Rector of the Church of the Holy Comforter in Charlotte.

Kanuga Conference

The Kanuga Conference is open not only to clergymen but to doctors, nurses, social workers, hospital administrators, personnel managers, and other persons concerned about the problems relating to alcohol. It is encouraging to see that the Episcopal Diocese is undertaking a conference such as this for the second straight year. There is no question of the great need for more understanding of the alcoholic and his problems by laymen and clergy of all denominations. The Episcopal Church is to be commended for its

(Continued on page 34)

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW HAMPSHIRE. Rev. David A. Works, President of North Conway Foundation announces a North Conway Institute, June 20-24, for clergymen of all faiths who have graduated from the Yale Summer School of Alcohol Studies or its equivalent. Idea behind the Institute is to further train clergymen so that they can return to their respective states and work more closely with the State Programs on alcoholism, Alcoholics Anonymous, and other interested groups in the field of alcoholism. A top-notch faculty has been recruited including Dr. Selden Bacon, Director of the Yale Summer School, Father John C. Ford, Dr. Ebbe C. Hoff, Dr. Dudley P. Miller, Bishop Charles F. Hall, and John Park Lee. Qualified clergymen wishing further information should write Rev. Works, North Conway, New Hampshire.

RUSSIA. The writings of almost every American who has had a peek behind Russia's Iron Curtain refer to the large number of heavily intoxicated men one sees on a casual stroll through a city's streets. We don't know that Russia's alcoholism rate is any higher than ours, but the difference in drinking customs may make the Russian variety of alcoholism more conspicuous. Observers tell us that there are apparently no "skid rows" in Soviet Russia, and little of what we know as "social drinking." The ordinary Russian who can afford to drink does so with a grim determination to achieve stuporous intoxication as quickly as possible. The favorite drink is what we would label a "boilermaker"—a tumblerful of raw vodka, followed by a schooner of beer. Two or three of these and the inebriate falls on his face and lies there, ignored by passersby, until a van hauls him away to a "sobering up" station. The Communists, apparently nettled by the comments of Western visitors, are currently crusading in the press against alcohol and alcoholism. Drinking is being denounced as—you guessed it—a "degenerate bourgeois-imperialist vice." Oh, well, they blame everything **else** on us "imperialists."

CHAPEL HILL. The staff of N. C. Memorial Hospital announces a change in admission policy for alcoholic patients as reported in the last issue of **Inventory**. Because of the lack of adequate facilities at this time it is impossible to admit Negro patients for the treatment of alcoholism. With the activation of more beds in the South Wing, hospital officials hope to be able to provide services for Negro patients desiring in-patient treatment. Negro alcoholics are still accepted for therapy in the Out-patient Service at N. C. Memorial. Watch for a full story of the N. C. Memorial setup in a coming issue of **Inventory**.

ATLANTIC CITY. An extensive new exhibit on alcoholism will be unveiled at the annual meeting of the American Medical Association in Atlantic City in June. Prepared by the A.M.A.'s Bureau of Exhibits, the display discusses the causes, diagnosis, and treatment of the illness, and depicts the progressive symptoms of alcoholism. Particularly stressed are the techniques used in treating acute alcoholic intoxication as well as chronic alcoholism. The exhibit also demonstrates ways in which community organizations—county medical societies, health and welfare organizations, Alcoholics Anonymous, etc. can help the alcoholic resolve his problems. After July 1, the exhibit will be available for showings at state medical society meetings and allied professional gatherings. Query the Bureau for further information.

ST. LOUIS. All AA roads lead to St. Louis, Missouri, where on July 1-3 the 20th Anniversary Convention of Alcoholics Anonymous is expected to bring together the largest number of members, their families and friends ever gathered in one place at one time. Co-founder, Bill W., will be present and is scheduled to make several key addresses, reviewing parts of his own personal story, and of the early history of AA that have never before been presented in detail at a major open meeting. There will be typical AA open meetings throughout the Convention, and approximately a dozen "workshops" and panel discussions will be held. Registration forms for the 20th Anniversary Convention may be obtained from General Service Headquarters, P. O. Box 459, Grand Central Annex, New York 17, N. Y.

BRITISH COLUMBIA. The Alcoholism Foundation of British Columbia, after five months of planning and investigation has announced an expanded program of rehabilitation and education. Plans call for the establishment of an out-patient clinic and information center, and the relocation and expansion of the already existing rehabilitation center to care for clinic patients requiring short term "boarding home" type of care. An educational program will be launched to increase public understanding of the illness and encourage problem drinkers to recognize their symptoms and seek treatment. The British Columbia set-up will also provide for research on alcohol, alcoholism, and related problems.

NORTH CAROLINA. The biennial report of the State's Attorney General shows that court convictions for all whiskey violations in 1953 (the latest year reported) totaled 59,051, down slightly from the 1952 figure of 60,080 convictions. Violations involving whiskey accounted for a sizeable 28.5% of all convictions in the North Carolina courts during 1953. Offenders convicted for drunken driving alone numbered 9,793.

RALEIGH. Just off the press is the latest pocket directory of all Alcoholics Anonymous Groups in North Carolina. This handy little booklet lists meeting places, hours of meetings, addresses, and telephone numbers of every AA Group in the State. Useful information not only for members of AA but for ministers, physicians, social workers, and others who may have occasion to refer alcoholics to AA. Copies of this directory may be had free by writing Box 5643, Raleigh, N. C.

ALCOHOL QUIZ — TEST YOUR KNOWLEDGE

When you have marked the answers you believe to be correct turn to page 34 and check your knowledge. No mistakes, Superior. Not over two mistakes, Good. Three mistakes, Average. Over three mistakes, Poor—Write for your free copies of *The New Cornerstones* and the *Treatment Center Brochure.*

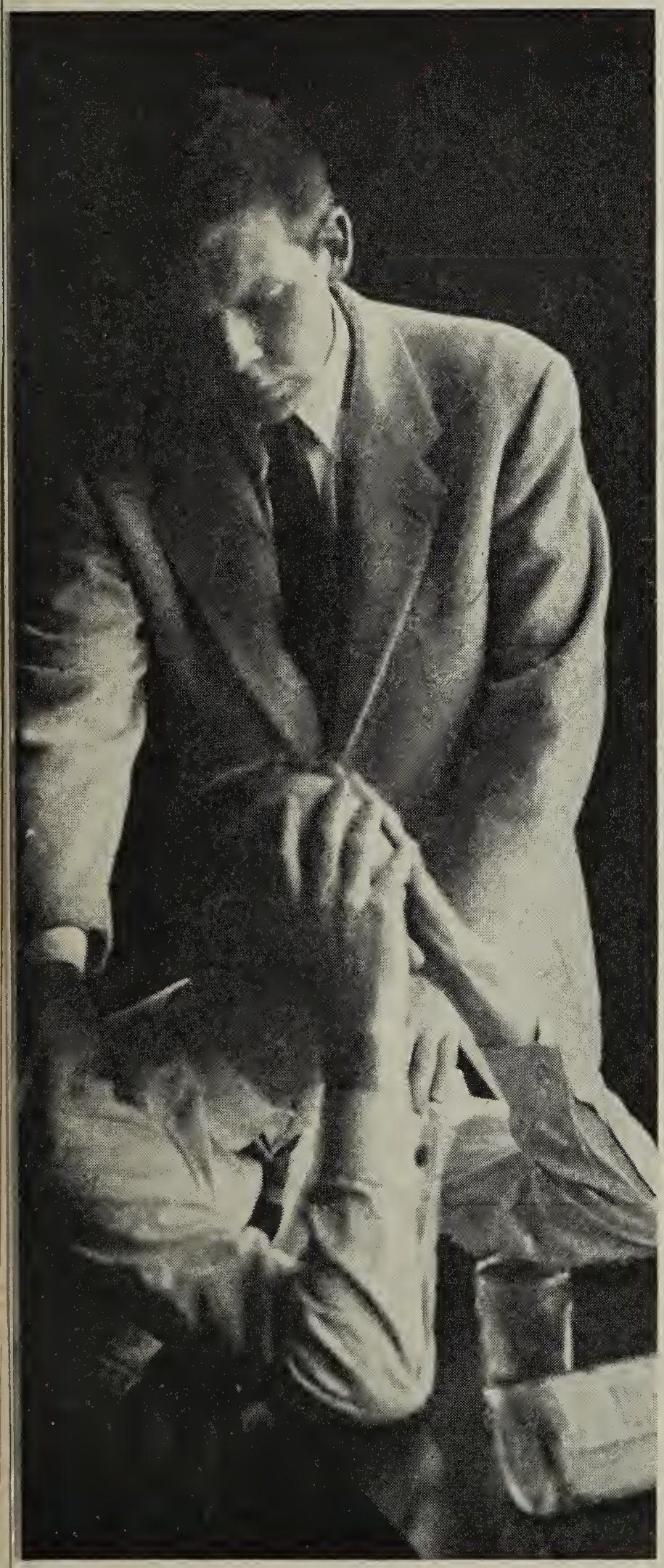
Place an X beside the correct answer:

1. Scientists describe beverage alcohol as
   a. A stimulant
   b. A tonic
   c. An anesthetic
2. Alcoholism is a sign of
   a. Moral inadequacy
   b. Personality disorder
   c. Defective will power
3. The N. C. voluntary treatment center for alcoholics is at
   a. Kinston
   b. Newton Grove
   c. Butner
4. Alcoholics Anonymous is
   a. An unofficial organization of recovered alcoholics
   b. The name of the State Farm for alcoholics
   c. A national organization not represented in N. C.
5. Out-patient clinics for alcoholics are
   a. Non-existent but greatly needed
   b. Not needed in North Carolina
   c. Located in the Mental Hygiene Clinics in N. C.

Is it TRUE or FALSE?	TRUE	FALSE
1. A person who drinks regularly sets up an increasing physical craving for beverage alcohol.	.....	.....
2. Some form of alcohol education is legally mandatory in N. C. public schools.	.....	.....
3. If he resolutely desires to, anyone can control the amount of alcohol he drinks.	.....	.....
4. The safest place for an intoxicated person is in jail.	.....	.....
5. Alcoholism is not inheritable.	.....	.....
6. As few as two or three drinks can impair efficiency and coordination in operating a machine.	.....	.....
7. The majority of alcoholics are fairly well socially integrated, living with their families and working.	.....	.....
8. The State Hospital at Dix Hill accepts committed alcoholics as patients.	.....	.....
9. Alcoholism can never be permanently cured.	.....	.....
10. Excessive drinking did not become a problem in the U.S. until the period of the First World War.	.....	.....

VOL. V, NO. 1 **INVENTORY** MAY-JUNE, 1955

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM



YOU CAN HELP HIM RECOVER

Knowledge and understanding are two of the tools you will need.

BY HORACE CHAMPION

THOSE of us who are not psychiatrists, pastoral counselors, or recovered alcoholics, are sometimes tempted to use our knowledge of alcoholism and our meager understanding of psychology or religion to "treat" our wives, husbands, brothers, or friends who have alcoholic problems, particularly when we love the person involved.

It's heartbreaking to see a loved one walk the rocky road to alcoholism and not lift a finger to help him. We *can* help him, and we should help him, but before we take upon ourselves the responsibilty of "curing" him we should stop and con-

sider how far we can go with the treatment.

Professional therapists and recovered AA members are highly skilled in using the tools which have proved effective in helping a person to recover. The principal tools might be listed as: knowledge, understanding, a higher level of emotional maturity, a definite plan of action based on training and experience, and in general a love for mankind and respect for the individual.

Goals Of Treatment

Not only are these the tools with which the therapist works—they are goals of the treatment itself. If the alcoholic is to remain sober and achieve peace of mind he must be helped to develop his own tools for fighting off relapses and unbearable tensions.

The therapist helps to fashion the tools; that is his job. The person or persons nearest and dearest to the alcoholic help him to keep the tools sharp and useful. Only the alcoholic himself can use them.

Like an apprentice electrician with unfamiliar tools he will be unsure of himself at first, and that should be expected. After all, the job of staying sober and facing problems realistically is a new way of life for him, and he should not be expected to become an expert overnight.

Let's take another look at these tools, which are in reality strengthened inner resources, and try to determine for ourselves how we may help him to become competent with them.

The first is knowledge. The alcoholic cannot overcome his illness without knowing what he is fighting. As people who want to help him it is equally important that we gain all the knowledge we can about the ill ness of alcoholism, its progressive symptoms, its causes, the resources to which the alcoholic can turn for help. We will gain new hope from this knowledge because we will know that alcoholics can and do recover from their compulsion to drink. However tempting it might be at this stage to share our knowledge with him we must resist that temptation successfully. There are other steps we must take before we can be of help to him.

Understanding Is Tool

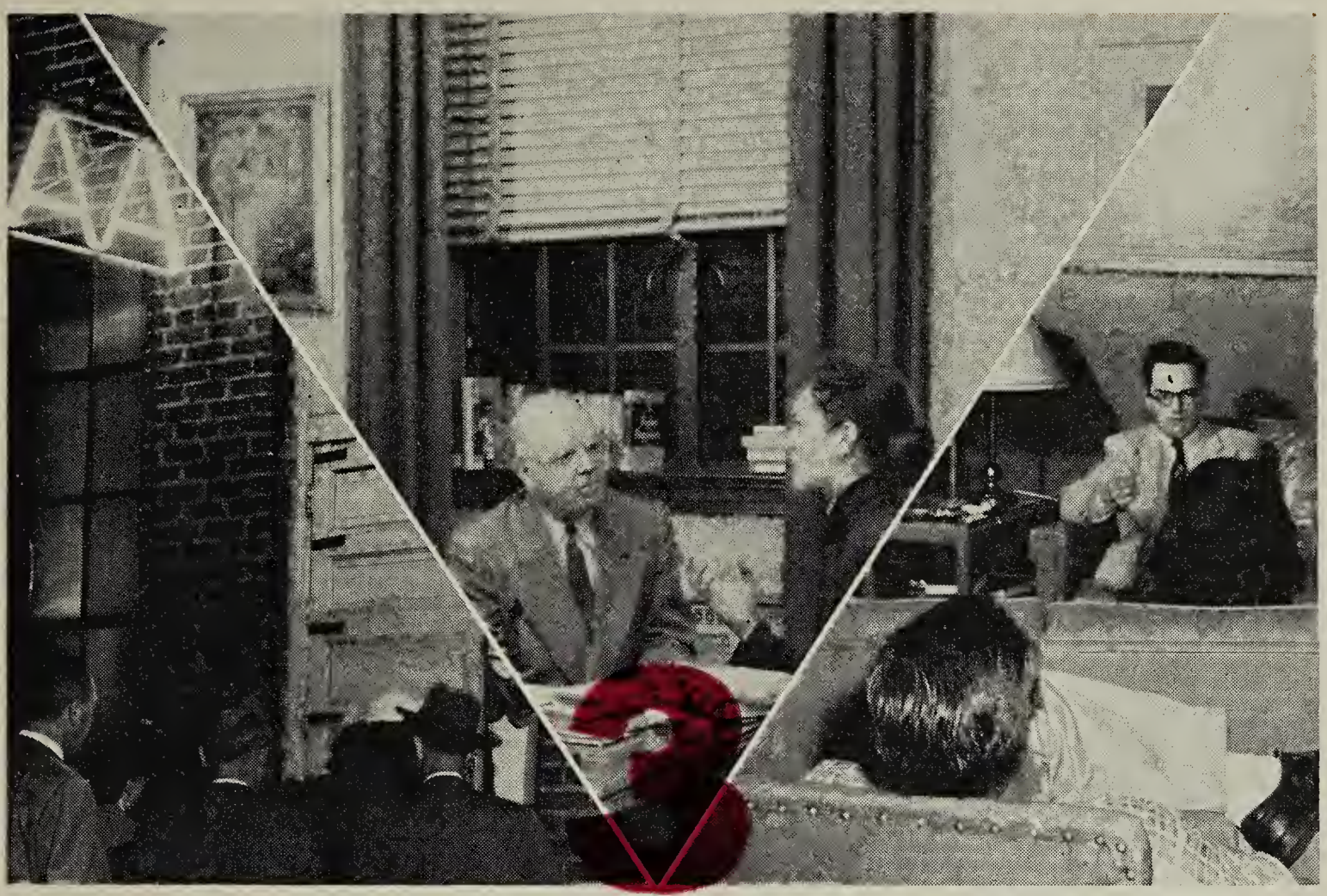
The second tool is understanding. It is the one which no one ever masters completely, but it is the key to sobriety for the alcoholic and we can use it to help him open the door to recovery. So it is vitally necessary that we, as would-be therapists, acquire all the understanding we can, realizing that understanding is relative.

A usual feeling of the alcoholic is that no one understands him. *They* don't understand why it is absolutely necessary for him to drink. *They*

(Continued on page 18)

ALTHOUGH anxiety is painful and one might wish that it could be abolished, it serves a very necessary function by alerting a person to the presence of internal and external dangers. Being alerted, he can do something to ward off the danger. On the other hand, if the danger cannot be averted, anxiety may pile up and finally overwhelm the person. When this happens, the person is said to have a nervous breakdown.

—Calvin S. Hall in *A Primer of Freudian Psychology*



WAYS TO RELIEVE RESENTMENT - AND ALCOHOLISM

In all successful forms of treatment the therapist seeks to eliminate resentment and to inspire love.

IN an article in the April issue of *Religion and Health,* a marriage counselor describes his part in helping an embittered young couple to save their marriage.

What struck us was the philosophy behind the counselor's action in helping to heal this sick marriage and the simplicity of his method.

This same philosophy, even the same method with variations, is a foundation upon which psychiatrists, pastoral counselors, and Alcoholics Anonymous help alcoholics to build lifetimes of sobriety for themselves. The practical wisdom of this approach to the problem of hate and other negative feelings becomes clear when one studies the techniques which have proved successful in the treatment of alcoholism.

In the case of the young married couple the counselor gave each a sheet of paper and asked them to write down everything which he or she did not like about the other. This they did with grim satisfaction, writing furiously until they both ran out of ideas at about the same time.

Collecting the papers, the counselor said, "Thanks for finishing the first half of my request. I am quite convinced that neither of you is

(Continued on page 20)

THE CHANGED ATTITUDE OF N. C. HOSPITALS

THE treatment center of the N. C. Alcoholic Rehabilitation Program specializes in the treatment of the emotional aspects of the illness of alcoholism.

This means that the responsibility for treating the physical ills of the prospective patient — malnutrition, pellagra, beri beri, delirium tremens, the shaking, trembling and sweating following a bender, etc.—rests with the local community; specifically, the family doctor and the community's *general* hospital.

Little Help At First

Shortly after I accepted the appointment as Executive Director of this Program in 1949 I learned that our alcoholic citizens could expect little cooperation from most local hospitals when trying to recover from the physical effects of excessive drinking. I was told by many hospital administrators that due to overcrowding, inadequate staffs, and a recalcitrant attitude on the part of most alcoholic patients, they did not feel that the alcoholic was an acceptable patient.

I was given the feeling that hospital staffs generally were of the opinion that alcoholism was more of a moral, social or spiritual problem than a medical problem. This was not true in all cases of course, but general hospitals which accepted alcoholics for treatment of the physical effects of drinking were not plentiful. I don't think that the attitude of our hospital staffs differed from those in other parts of the country. In fact, I understand that the vast majority of general hospitals in the United States today still do not accept alcoholic patients for treatment.

I am very proud to announce that the situation in North Carolina in 1955 is completely reversed. A majority, 76 per cent to be exact, of the general hospitals in North Carolina are now accepting alcoholics for treatment when requested to do so by a member of the hospital's medical staff. I know that this is

A majority—76 per cent to be exact—of the general hospitals in North Carolina are now accepting alcoholics for treatment when requested to do so by a member of the hospital's medical staff.

BY S. K. PROCTOR
EXECUTIVE DIRECTOR
N. C. ALCOHOLIC REHABILITATION PROGRAM

true because I have a signed statement from every general hospital in the State regarding its policy on the admission of alcoholics as patients.

Of this majority, 49.7 per cent accept alcoholics as patients without qualifications. Only 26.1 per cent stated that they require the alcoholic patient to meet special conditions on admittance. A sampling of statements from the latter category indicates that the requirements are not unreasonably stiff.

Conditions Of Acceptance

Several hospitals accept them on the condition that "the patient is not too unruly." Others, "Yes, provided the patient provides special duty nurses." "Yes, provided the hospital rules and regulations are followed 100%."

Only 24.2 per cent of the general hospitals in the State answered "No" to the question which I put to the administrator of each general hospital in February and March of this year. The question was printed on a return postcard enclosed with my letter to them explaining that we were anxious to know the hospital's present policy regarding the admission of alcoholic patients.

The question was as follows: "If a member of your medical staff felt that an alcoholic patient was in need of hospitalization, would the physician be permitted to admit the patient to your institution for treatment?" YES..... and NO..... were printed beneath the question, and space was provided for any comment they might care to make. A signature was requested.

The response exceeded my highest expectations on the first mailing. A small minority that failed to respond were mailed a second letter and card, and most of them responded. Less than five general hospitals remained to be heard from at the end of March and we contacted these personally, securing the information we needed. Consequently we received 100 per cent response from the

(Continued on page 24)

AN ARTICLE FOR MEDICAL DOCTORS—

THE TREATMENT OF ACUTE

The author has treated many hundreds of cases of acute alcoholic intoxication at St. Michael's Hospital. Herein he describes in detail his treatment methods for all stages of acute intoxication.

BY W. E. HALL, M.D., F.R.C.P.(C)*

Reprinted with Permission from ALCOHOLISM RESEARCH, Magazine of The Alcoholism Research Foundation, Toronto, Ontario, Canada

IT is possible to treat acute alcoholic intoxication in hospital very quickly and effectively by well tried methods. In fact there are few medical conditions which respond so rapidly and so well to specific therapy as does this form of intoxication.

The first step in the successful treatment of the acute alcoholic is to make him feel that he is being accepted as one who is ill. He requires encouragement and must be approached sympathetically. He must not be aware of resentment on the part of doctors, nurses or attendants. If he is shown resentment he will in turn become resentful and develop into a behavior problem.

Many hospital administrators, nurses and staff doctors have an unconscious resentment toward, and a fear of, the acute alcoholic. They look on him as one who should not have allowed himself to reach such a state. They neglect or are unaware of the fact, that the man has a strange, poorly understood disease. Like many lay people they look at the disease as a self-inflicted one which will not kill the patient; and therefore they feel that there are others who need the hospital's services more.

Unpleasant Memories

Hospital personnel may have unpleasant memories stirred up by the word "alcoholic". They recall the "Skid Road" alcoholics who have gone through the emergency ward with lacerations, fractures and head injuries. The burdens which these individuals have brought to the hospital in the form of intoxicated friends, crying families, and enquiring police come quickly to mind, and

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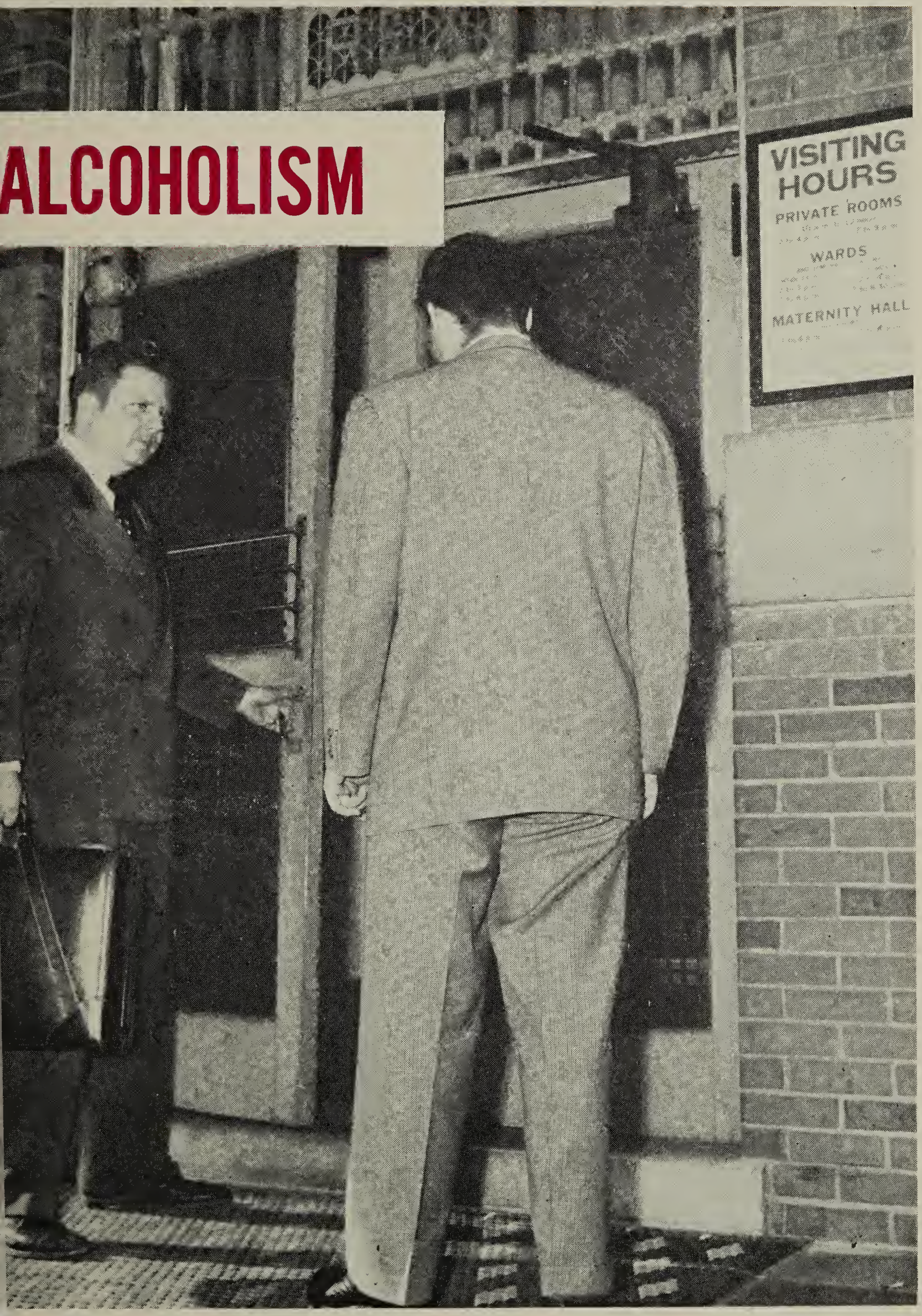
**Dr. Hall is a staff physician at St. Michael's Hospital, Toronto, and has charge of the Foundation patients who receive treatment there for acute alcoholism. He is an Associate in Medicine at the University of Toronto.*

ALCOHOLISM



TEACH MY CHILD THE

Give our children the facts and they will be better equipped to overcome the problems of alcohol.

LUCY is a normal, attractive young lady in the eighth grade whose main interests are food, new clothes, telephone calls, her parents, and that "nice" boy who sits across the table.

She lives with her parents and a young brother in a modest home on the West Side that is almost paid for. Already her parents are happily planning the "mortgage burning" party for next month. There will be dancing and talking and laughing . . . . and cocktails.

Ordinarily, Lucy would be unconcerned about the cocktails. Her daddy and mother sometimes offer them to guests when they come to play bridge or talk. Her parents don't drink every night, or every week, and she has never observed any drunkenness in the home, but tonight Lucy is worried.

Today at school her teacher lectured the class on "the evils of alcohol." And tonight the bitter words of condemnation and accusation are echoing through her confused mind.

"Alcohol," the teacher had said with considerable feeling, "is the greatest evil that has ever befallen

Mrs. Margaret Copeland, who attended summer studies on facts about alcohol, lays groundwork for prevention by giving pupils the facts.

FACTS ABOUT ALCOHOL

BY HORACE CHAMPION

mankind. Only the weak, the stupid, the social misfits, and the sinful use it. Alcohol is a slow poison that destroys brain cells and eats away the stomach. It atrophies the liver. It turns man into an animal that destroys everything around him. It is the greatest single cause of murder, divorce, traffic deaths, and juvenile delinquincy."

Livid with rage against users of alcoholic beverages she wound up the harangue with, "People who drink socially are worse than those who drink to excess because they *know* better!"

So tonight Lucy is confused. She feels that her parents are not weak, or stupid, or social misfits, or any of those things the teacher said. Lucy considers her parents kind, loving and considerate. They have nice friends and they have a happy home life. But the teacher said that alcohol is a *slow* poison. How slow? What will happen to them next year, or the next? What does alcohol really do to people? Why do people drink?

Lucy would like to know the real

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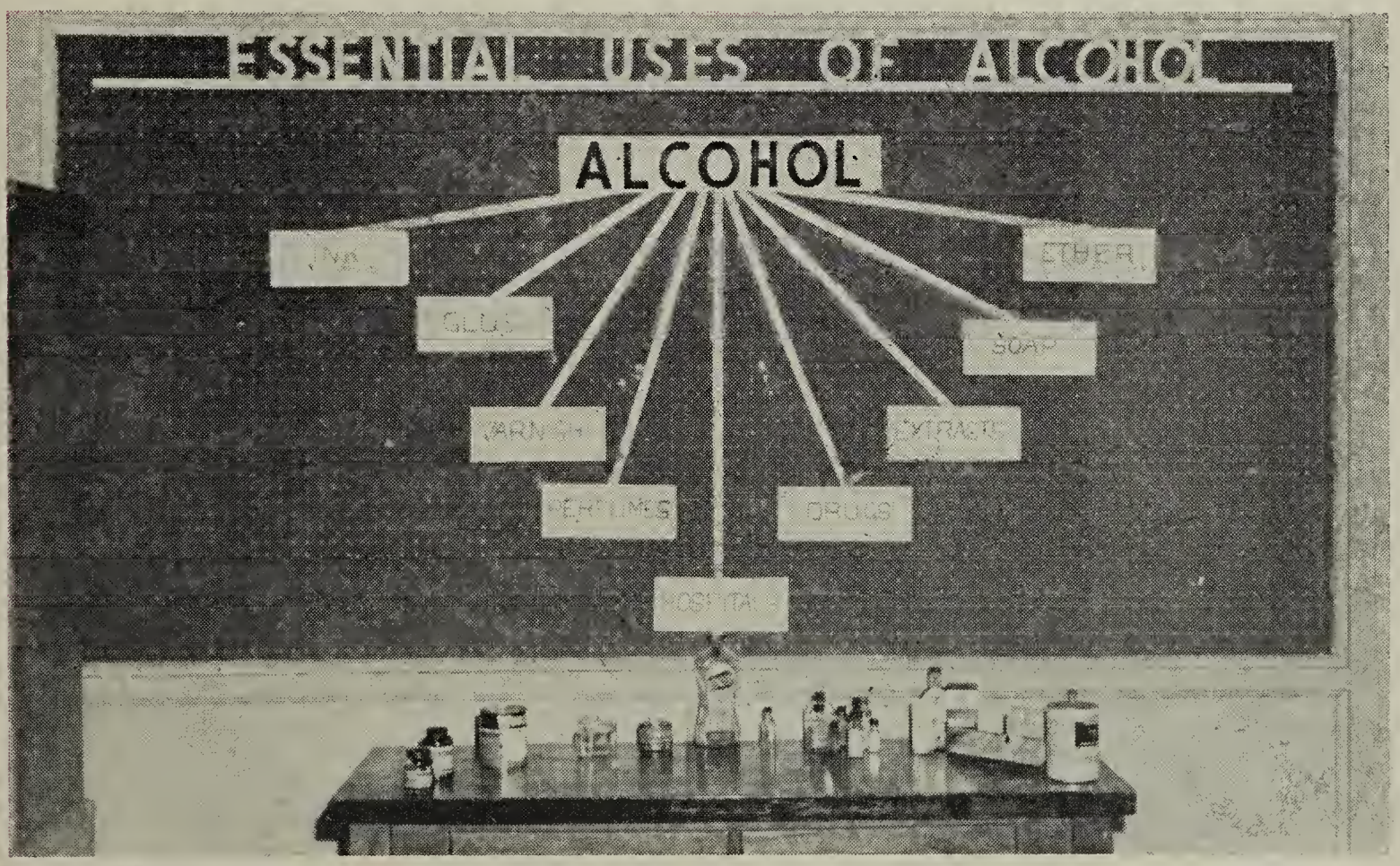
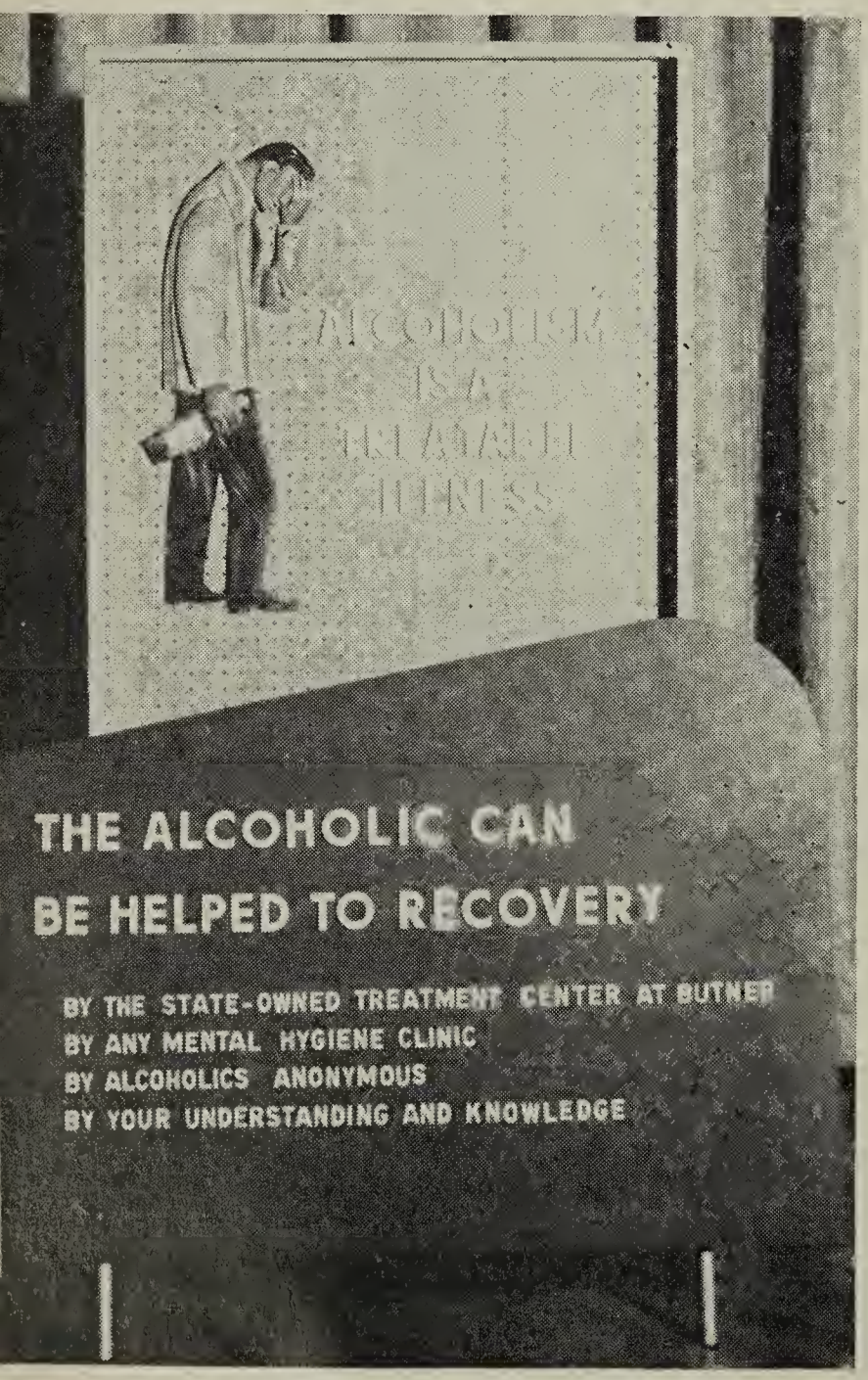


Mrs. Copeland's pupils learn the facts about alcohol and alcoholism, including commercial uses of the chemical. Her pupils made display.

The ARP educational exhibit consists of three separate pieces professionally designed with an eye to beauty as well as portability.



This colorful panel brings a message of encouragement.

EDUCATIONAL EXHIBIT AVAILABLE FOR CONVENTIONS, DISPLAYS, FAIRS, ETC.

HERE is the ARP's portable educational display now available for use at public meetings and conventions, in display windows, and other suitable public places anywhere in the State.

Constructed in three separate pieces, including an eye-catching light panel flashing the "warning signals" of alcoholism, the display is colorful, handsome, educational—a real attention getter.

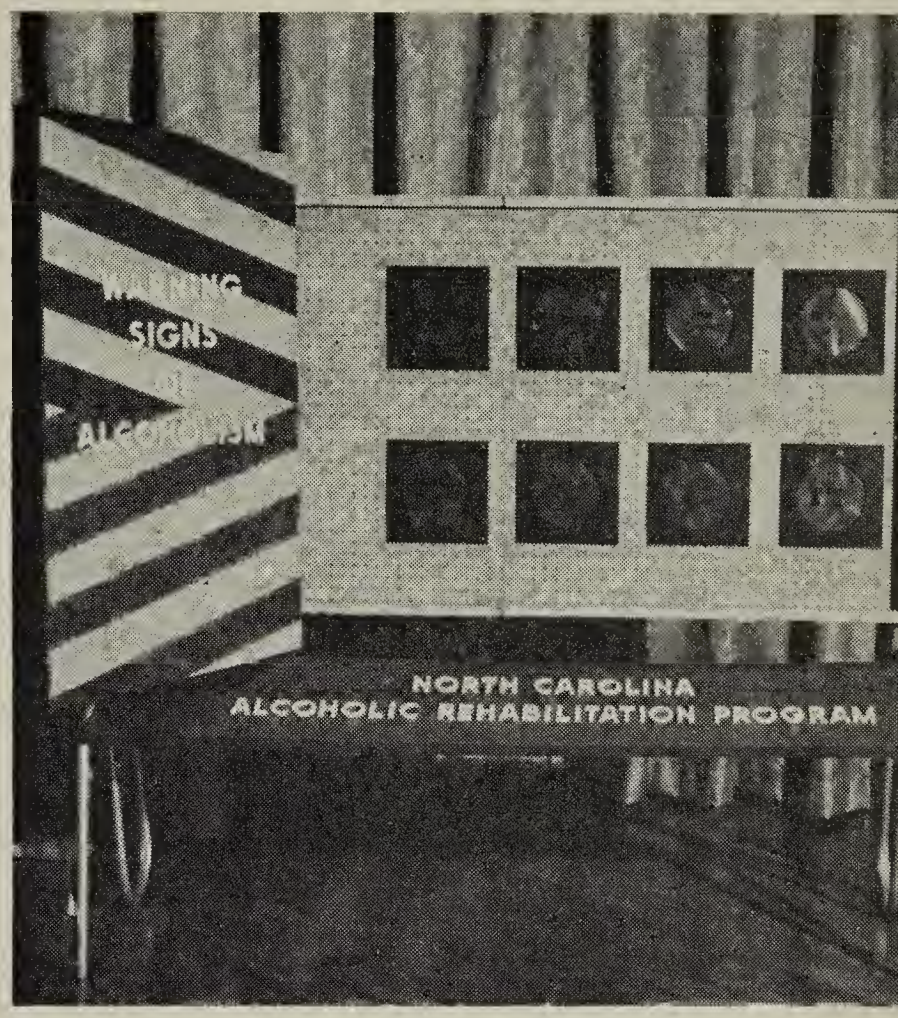
Designed by a professional designer with an eye to portability as well as beauty, the display may be dismantled quickly and reassembled with a minimum of effort.

Its educational message is basic to an understanding of the problem of alcoholism. The warning symptoms are vividly portrayed. A second display piece allays fear and delivers a hopeful note — "The Alcoholic Can Be Helped to Recovery"—and outlines sources of help. A third segment is a compact storage and display table for ARP literature, wherein the message of prevention and recovery may be read in greater detail.

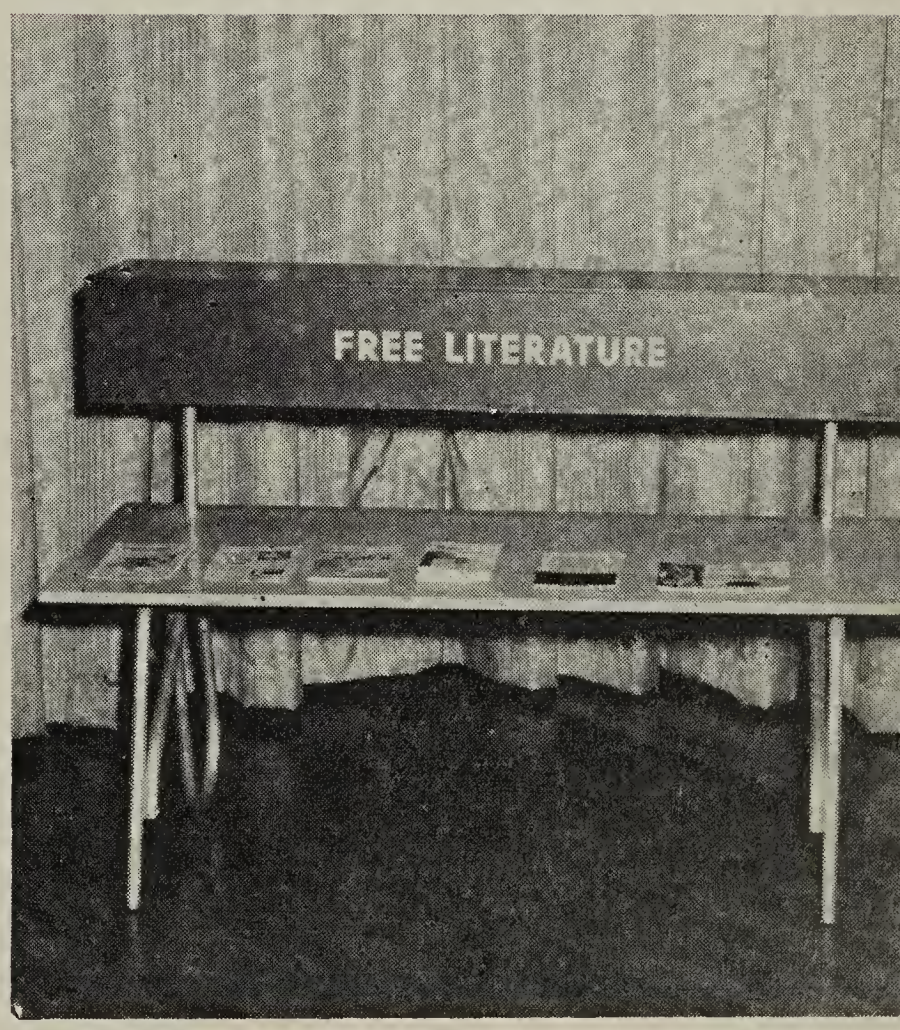
The exhibit was first unveiled at the 1954 N. C. State Fair, where it attracted widespread attention. It has since been seen by medical conventions, community institutes, and other gatherings.

The ARP now makes the exhibit available for a limited time to any interested person, group, or organization in the State who can assure its favorable location for maximum public viewing. Enlarged photos of the display may be obtained on request to the ARP.

Arrangements for borrowing the display may be made by writing S. K. Proctor, ARP, 15 W. Jones St., Raleigh. Inquiry should be made *well in advance* of the date the exhibit is to be used. Transportation to and from the display site will be furnished.



Flashing lights tell of alcoholism's warning signals.



ARP literature on alcoholism is displayed on table.

You Can Help Him Recover

(Continued from page 8)

don't understand how a man gets this gnawing, unbearable feeling inside that fairly screams for the relief that only alcohol gives him. Neither does *he!* That's why any suggestion to him that he straighten up and stop drinking altogether only makes matters worse. He doesn't understand, and neither do we.

Nor should we attempt to understand him just now. Our greatest help to him at the moment will come from a greater understanding of ourselves and our own part in the pathetic drama in which he is merely one of the actors.

There is a good possibility that we have at least some of the negative feelings and bitterness possessed by the person we want to help. His uncomfortable feelings and resulting tensions are probably greater than ours, but if we are to help him to be more comfortable in his relationship with us we ought to take stock of our own attitudes and feelings in an honest attempt to understand our own strengths and weaknesses. Understanding ourselves will be the beginning of our help to him, because it will relieve us of some of our own tensions and give us more confidence in coping with the problem. We will see ourselves—and him—in a new light. We will realize that our negative feelings and attitudes are harmful to us and to him, and we will take steps to eliminate them so far as is possible.

Toward determining whether our attitudes are as healthy as we would like them to be, we can ask ourselves these questions as a starter: Have we developed a positive attitude toward life and our own problems? Are we victims of self-pity, self-blame, and general unhappiness? Have we ourselves the peace of mind that he is searching for? Do we try to control the lives of others? Are we punitive in our relationships with "weaker" persons?

Seeking Maturity

How much help do *we* need in order to achieve peace of mind? If necessary, are we willing to go to the pastoral counselor, psychiatrist, the Mental Hygiene Clinic, or open meetings of AA to seek some measure of this peace? Have we the same kind of pride that prevents him from seeking help? Have we

PANGS OF CONSCIENCE

THERE is a constant danger that besets us—the danger of damnation, of being judged by our own strict conscience. As man grows up, his parents' and teachers' ideal of what he should become has been built up through the years into an awful tyrant, an avenging, punishing Jehovah, a Superego. This false god, like a dictator, gives us no peace. We are told to "let conscience be your guide." This is *wrong.*

Constantly making us feel guilty or ashamed, driving us ever on to bigger and more demanding duties, we listen to the voice of conscience even in our sleep. No wonder we become sick again—anything for a rest, anything to atone—even pain, terrible pain, the tortures of hell.

—Charles T. Bingham, M. D., in *Religion and Health*

acquired the humility to admit our own shortcomings? He cannot recover from the illness of alcoholism without acquiring humility, and we cannot help him very much unless we have it, too. Humility springs from understanding and implies tolerance, self-acceptance, and respect for others.

We can assume that we have acquired enough understanding to help our alcoholic recover when: (1) We have begun to think positively about his condition, believing that he will sooner or later seek treatment and recover; (2) We no longer feel panic-stricken at the immediate prospect of a new bender, realizing that our own peace of mind is the most important thing to us and the greatest support to him in an impending crisis; (3) We have reviewed our past experiences with him as a sober and an intoxicated person, can see our own mistakes in coping with the problem at those times, and feel reasonably confident that we will not repeat our mistakes in the future. We may make new mistakes but we will avoid the old ones like the plague itself.

The next step is to develop a plan of action that will aid him directly. Up to this point we have been laying the groundwork, gaining knowledge and understanding and at the same time achieving a healthier degree of emotional stability. We will now begin to use these new tools to help our alcoholic friend or relative build a foundation for sobriety.

With confidence we can now calmly explain to him what we have done. We should do this when he is sober and rational .With our own bitterness at a low ebb and with an attitude of calm hope we can ask him to read some of the literature we have studied.

He may become angry with us for subtly suggesting that there are resources to which he can turn for help, and if he does we should drop the subject but leave the literature where he can read it later. The chances are good that he will read it sooner or later and subsequently want to discuss it with us.

Don't Push

This first step is a big one for him to take. We should not push him into it, nor should we be discouraged if he does not take it right away. We must not forget that our own peace of mind is still the most important matter. We are helping him more than we realize by maintaining this state of mind, by not nagging, by remaining as unruffled as we possibly can, by trying to substitute a positive thought for every negative

ALLEGIANCE TO PARENT

THE male child must, if he is to make any sort of happy adult adjustment, identify himself somewhat with his father or with some other grown man. No matter how close, how affectionate, how deserving of admiration and allegiance his mother may be, she does not offer the male child a way of life. If his allegiance to her is too close, it will stunt his emotional development; if he identifies himself with her it is at the risk of becoming an invert, or at best of making some fantastic and uncomfortable emotional adjustment. The heaviest prices which family life demands from children are those which result from an antagonism to the father and an overdependence upon the mother, for a boy child, and the opposite set for a girl.

—M. Mead in *Growing Up In New Orleans*

thought that comes into our minds.

We shall avoid any verbal abuse from him, and not be drawn into an argument, especially if he has been drinking. For our own self-respect, however, we cannot allow ourselves to be scapegoats for his resentments and defiance. Should he become abusive we can leave, the length of time depending on our own personal experiences of this kind with him.

Without someone on whom to vent his pent-up feelings he may feel compelled to "talk it out" with someone qualified to drain him of his tensions and help him to that peace of mind and permanent sobriety he wants so much.

Believing

That is our hope, and we must not lose it, because our own future happiness with him, and his with us, hangs in the balance. We must believe sincerely that he will eventually admit to himself that he is suffering from an insidious illness and will seek competent help. He will do this just as surely as he would if he were suffering from tuberculosis or pneumonia. With our continued understanding and love to help support him that day will arrive much sooner.

And when it does we must guard against the feeling that our job is done. It has just begun! If the treatment he has chosen of his own free will has been effective he will be ready to accept and return our love in a more mature manner.

More than ever before he will need our understanding and help toward adjusting happily to life situations. It will be a new world for all of us, one in which the trials and tribulations will continue, but this time the trials and troubles will not be seen through the eyes of resentment and other negative feelings. They will be faced realistically and in a positive manner through the power of love.

Ways To Relieve Resentment - And Alcoholism

(Continued from page 9)

dumb or lacking in good judgement. I am certain that each of you must have seen some good qualities in the other at some time. Now write down all—and I mean all—of the good things, the nice things which you can recall, present or past, about the other. Be as honest in this as I know you were in the first half."

This unexpected turn of events embarrassed them, and they were slow to respond. Faced with the open admission of their bitterness toward one another, however, and perhaps wanting to win the approval of the counselor, they were more or less forced to follow his suggestion.

They sat for a long time in silence, each striving consciously to remember the good things about the other. Finally the girl gave in by rapidly scribbling down a few words. Her

WHY WORRY?

Today is that Tomorrow you feared so Yesterday.
And cares you tried to borrow, you find have skipped away.
Remember how you fretted at things that might befall?
And what was it you netted? You aged yourself, that's all!
We have enough of trouble from which we cannot flee—
So let's not make it double with cares we *think* we see.

—Author Unknown
Quoted in *Religion and Health*

husband followed by a similar act.

Then the counselor noticed a peculiar thing taking place. Little by little, line by line, their tensions began to ease, and soon each was writing rapidly and freely. There was an exchange of glances, an uncertain smile from the husband, quickly returned by the wife. The smiles broadened and suddenly they laughed out loud in a spontaneous surge of emotional relief.

Hand in hand they walked out of the counselor's office, explaining happily that they were "going home where we belong—to *our* home, that is."

What are the factors involved in helping these "sick" people to save their marriage that can help the alcoholic to recover from his illness? He too is filled with bitterness and hate, resentments and defiance. He too "puts the blame on Mame", unmindful of his own contribution to the calamity. He too needs skilled help in overcoming his problem, which is basically a problem of negative feeling.

The same technique—if you can call it that—employed by the marriage counselor to unite the estranged couple is being used with variations every day by psychiatrists, pastoral counselors and by Alcoholics Anonymous to enable alcoholics to live with themselves and operate satisfactorily with others in their environment.

Getting Rid Of Hate

In his own way each of these therapists seeks to eliminate resentments and inspire love, and to help the sick person to understand himself. He seeks to eliminate the resentments, not by smothering or ignoring them, but by helping him to express them in a setting that will render them harmless. Resentment must have an object and the alcoholic usually has a multiplicity of such objects—the wife, the boss, circumstances—but the one that he resents most is himself and his inability to meet the demands of conscience and society.

Like the unhappy married couple, he either attributes his failure 100 per cent to others, or he blames himself 100 per cent. In either case he is mistaken but he will keep on wallowing in his misery until he can express his bitterness freely and completely to someone he *knows* will listen and understand without passing judgment, someone who will accept him without conditions, someone whose great faith in man and love for mankind is strong enough to support them both until he can develop his own faith and love.

Where can he find such a person? It might be difficult, especially for a discouraged alcoholic, to believe that there are such people to whom he can turn. Being ordinary human beings, however, these "healers" cannot approach the perfection of the

TODAY

Look to this Day
For it is life, the very breath of life.
In its brief course lie all the
Realities of your Existence:
The Bliss of Growth
The Glory of Action
The Splendor of Beauty
For yesterday is already a dream
And tomorrow is only a vision.
But today, well lived
Makes every yesterday a dream of happiness
And every tomorrow a vision of hope.
Look well, therefore, to this Day!

—Kalidasa

greatest Healer who ever lived, but all present-day therapists whose business it is to help heal broken hearts, broken homes, or broken-down alcoholics, have learned in their small and limited way to use some of the techniques of the Master Healer.

Therapy Of Love

Whether the alcoholic turns to the psychiatrist, the understanding minister, or to Alcoholics Anonymous, he will find the therapy of Love in action. The fact that he may already have submitted himself to the therapy of one or the other and failed to achieve recovery should not discourage him. Love cannot be forced on a person, and it is possible that he was not ready to accept this great healing power. Or he may have been coerced into a form of treatment that was unacceptable to him. He may find the answer to his problem in the one he has not tried.

The psychiatrist may not ask the alcoholic to write down all the things he doesn't like about himself or others but he will insist that the patient talk about these things freely, to "get them out of his system." With understanding and scientific skill the psychiatrist drains the patient of his resentments, which are always harmful and negative. And when this has been accomplished he mobilizes the positive forces of love by helping the patient to appreciate the "good" things in himself and others and his environment. This is an over-simplification of a psychiatric approach to be sure, but in a situation of this kind it is *one* of the goals of psychiatry. Wasn't this also the goal of the marriage counselor?

Neither does the skilled pastoral counselor judge or condemn the alcoholic. He too encourages the alcoholic to speak from the heart, to tell what is really bothering him. He listens. He understands. He accepts. And in a setting which is itself a spiritual and material expression of man's faith and love, the counselor offers a way of life sustained by the infinite power of God's love.

There again we have the open admission and expression of negative thinking and feeling to another person whose understanding and skill enables him to relieve the tensions and make room for a positive approach to the problem based on love.

Alcoholics Anonymous also makes effective use of this principle in its *Twelve Steps* to recovery. The therapist is not a skilled, professional healer. He is an amateur, a cab driver, clerk, laborer, or business tycoon, but through the personal experiences of many thousands of recovered alcoholics, including himself, he has learned to use the power of love. In helping an unrecovered alcoholic to take the *Twelve Steps* he follows a proven pattern for relieving negative self-feeling and stimulating love.

Steps Four and Five require the alcoholic to search within himself for attitudes, feelings and behavior which are negative and therefore

★

RESIGNATION is not adjustment. The only true adjustment, the one for which the human mind and body are equipped, lies in the choice between *fight,* which is an effort at adjustment, and *flight,* which is the act of getting out of an unwholesome situation. Resignation does not end our dissatisfaction. We do not "forget it." We only stifle the open protest. We bury the conflict—and thus give our dissatisfaction the greater power to do us harm.

Arnold A. Hutschnecker, M. D. in *The Will to Live*

harmful, and to admit the exact nature of these wrongs to himself, to God, *and to another human being.* In AA that human being is a recovered alcoholic who understands and accepts the sick alcoholic for what he is.

The therapy of love is not a monopoly of the professional therapist by any means. This does not mean, however that anybody can sit down with the alcoholic and say, "Look, pal, I know just how this thing works. All you have to do is tell me everything that's bothering you. Tell me your innermost thoughts, and you'll feel so much better you'll never want another drink."

It's not that simple. In fact, it's very complex and requires much more skill, understanding and objectivity than any friend, wife, or relative can administer. These people can, however, contribute much toward his motivation for treatment and his continued sobriety. How this may be done is explained in another article in this issue.

Ideally the alcoholic comes to the therapist, not the therapist to the alcoholic. This presupposes at least some desire on the part of the alcoholic to receive treatment for an illness which he knows he has. In the second place, the therapist is an individual qualified by training or experience to help relieve the underlying tensions which cause the drinking. Thirdly, the alcoholic can express his hates, fears and anxieties to any of the three therapists described without fear of condemnation, judgment, or contempt. Also, because the relationship between therapist and alcoholic exists solely for the purpose of helping the alcoholic to become a well person the feelings expressed by the alcoholic and the suggestions offered by the therapist can be absorbed harmlessly. **—HORACE CHAMPION**

IT'S BEEN SAID THAT . . .

They can because they think they can.—Vergil

It is better to understand little than to misunderstand a lot.—A. France

Truth may be blamed but cannot be shamed.

Wisdom is the principal thing; therefore, get wisdom; and with all thy getting get understanding. —Bible

You may lead an ass to knowledge, but you cannot make him think.—Cynic's Calendar

A retentive memory is a good thing, but the ability to forget is the true token of greatness.—E. Hubbard

Blessed are they who expect nothing for they shall not be disappointed.—Sandburg

I want, by understanding myself, to understand others.—K. Mansfield

The wound unuttered lives deep within the breast.—Vergil

Which has been indulged to excess always produces a violent reaction.—Plato

Every slip is not a fall.

There is a natural body, and there is a spiritual body.—Bible

Women are wiser than men because they know less and understand more.—J. Stephens

The Changed Attitude of N. C. Hospitals

(Continued from page 11)

State's 153 general hospitals.

My gratitude for this degree of cooperation was exceeded only by my grateful appreciation to the 116 hospital administrators for their replies of "YES" or "NO" with qualifications.

In my opinion never has so much progress been made in such a short time toward the goal of adequate medical care for the physically ill alcoholic citizens of any State. We have good reason to be proud of the 116 general hospitals in our State now recognizing alcoholism as an illness and the physically ill alcoholic as a person who needs and deserves the medical services which they are able and willing to offer.

Appreciates Problems

As a former hospital administrator myself I can appreciate the many problems which face administrators when asked to admit patients of this type. To overcome them requires much understanding and educational work with other members of the hospital's staff, particularly nurses and aides.

Some alcoholics *are* unruly on admittance, sometimes delirious, and if there is no specially equipped room for this type of patient, he can be quite a problem to the staff. Some administrators have apparently solved this problem by requiring special duty nurses, attendants, or other responsible persons to be present during the obstreperous period.

Many administrators of hospitals having long experience with alcoholic patients have assured me, however, that most of the fears administrators have regarding the acceptance of alcoholic patients are ungrounded. I am told that few of them become obstreperous, that as a rule they are very grateful for the hospital's services and are usually most cooperative. I understand also that alcoholics pay their hospital bills as well as other medical cases.

Causes Of Progress

What brought about this welcomed change of attitude toward alcoholic patients in the general hospital? In retrospect I can list several things that have happened that might have contributed to the change, no one of which by itself is entirely responsible but all of which together have brought about this new hope and help for sick alcoholics.

For one thing, AA has been active in North Carolina for a long time. It has exerted a tremendous influence on public opinion and professional understanding regarding the *illness* of alcoholism. Without this influence we might not have our State Program on Alcoholism today.

With the money made available by the 1949 Legislature to establish the

TEMPORARY SOLUTION

THE underlying cause of alcoholism in women and men is the same—emotional immaturity, which renders their personalities unequal to the task of facing reality. In their narcotic use of alcohol they find the answer at least temporarily, and to the emotionally immature the temporary solution is sufficient. This temporary escape from reality is soon extended into days and weeks.

—Francis T. Chambers, Jr. in *Mental Hygiene*

N. C. Alcoholic Rehabilitation Program we were able to carry on extensive educational and informational services in addition to setting up a State-owned treatment center for alcoholics. It is with pardonable pride I hope that I express the belief that our services have contributed something toward a greater understanding of alcoholism as a many-sided illness and the greater interest being shown by hospitals and general practitioners toward helping alcoholics recover. Every medical doctor and every hospital administrator in North Carolina is on the mailing list of *Inventory* and have received other materials from this office that were designed to help them in their work with alcoholics.

The greatest influence has undoubtedly been the changing attitude of the general public toward alcoholism and alcoholics. I believe that the majority of our citizens now accept the modern concept of alcoholism as an emotional, physical, social and spiritual illness, one which requires the cooperation of therapists in all these fields to attain the goals of adequate treatment for all alcoholics and ultimate prevention of the illness itself.

The community's general hospital is a natural and convenient resource for the physical recovery of the sick alcoholic. Its policies usually reflect the desires and attitudes of the community it serves. I am glad that there are at least 116 communities in the State today where our alcoholic citizens can receive local hospitalization and adequate medical treatment when they need it. It is my hope that the remaining 37 general hospitals will eventually see fit to open their doors and offer their facilities to sick alcoholics.

RESPONSIBILITIES OF THE CHURCH

THE church and religion must increasingly recognize the alcoholic as a sick person, as one who has no more control over his drinking than one who has pneumonia has over that type of illness. When the drinking is out of control our concern is to help the suffering person and those closely associated with him.

This is basically religion's message in all areas of life: redemption, rehabilitation, health. This message organized religion communicates not through words but through demonstration, through affection. The alcoholic feels himself to be rejected, and religion seeks to convince him he is accepted.

The churches' greatest contribution to this problem is ultimately in the field of prevention. By prevention I do not refer to the control of liquor; this is relatively unimportant so far as the alcoholic is concerned. He will get his liquor or he will kill himself until he has a program of rehabilitation under way. Rather I refer to the building of better marriages, better child care, the relief of stress in general, building up the sense of dignity within the individual, so that he does not fall prey to the onslaught of the illness of alcohol, or similar illnesses of equal destructiveness. Just how all this is to be done we are, at present, uncertain, but this is our hope and purpose.

—Russell L. Dicks in *Religion and Health*

The Treatment Of Acute Alcoholism

(Continued from page 12)

resentment is aroused toward the acceptance of another alcoholic inside the hospital. The hospital staff does not make any distinction between the psychopathic alcoholic and the non-psychopathic alcoholic who is not a troublemaker.

The vast majority of patients with acute alcoholism are not noisy, injured or encumbered by police and relatives at the hospital door. For the most part they are fairly responsible citizens who are very ill and in great need of special treatment. If treatment is given they will be restored to a relatively good state of health in a few days. If treatment is not given they will become more severely ill and continue to be the despair of themselves and their relatives for an indefinite time.

Major Step

Practising physicians are very much aware of the havoc which alcoholism creates with respect to the patient's health, family and prestige. When it is possible for the hospital personnel to see the alcoholic from the point of view of the family physician and thereafter to admit the patient as a deserving individual, the major step toward recovery has been taken. The next few stages are clear-cut and certain to produce complete recovery from this particular episode in his illness. It is vital, however, that the physicians and nurses undertaking treatment of alcoholics realize that the improvement in health will be only temporary unless the patient proceeds to further help with his many problems. "Sobering up" the alcoholic merely represents the termination of one acute episode in a prolonged chronic illness. The treatment of acute intoxication should be the first in a program of rehabilitation.

Alcoholic Patient

What sort of patient is the alcoholic when he reaches the ward? One of our nurses with three years' experience in handling alcoholics has said: "Alcoholics are interesting people to treat. If you treat them from the first as sick people and never let them feel that you are looking at them as just another drunk, they are easy to handle. If you humor them and have the right attitude towards them they will accept whatever treatment you want to give them. After 24 hours they are very cooperative and more appreciative than the average patient. They recover so fast that they break the monotony of the ward."

In the literature there are many references to the advantages of treating the alcoholics on a general ward. When St. Michael's Hospital began to accept patients for the Alcoholism Research Foundation, the director suggested that the patients be admitted indiscriminately to any ward where a bed might be empty. It was indicated that it would be bad policy to have beds set aside as "alcoholic beds" and have a stigma attached to anyone admitted to such beds. Over

IN the year ending July 1, 1953, the National Institute of Mental Health had $3 million for research while the Department of Agriculture spent $40 million on hoof and mouth diseases in cattle, alone.

—Russell Dicks in *Religion and Health*

the years the wisdom of this suggestion has been borne out. Patients have appreciated the fact that they have been treated like others. Their self-respect which returns with sobriety has not been needlessly injured. Many who have required second admission to the hospital have requested that they be admitted where they can become lost in the midst of many and not segregated in a labelled bed.

Help Each Other

Other advantages have come from having the intoxicated and the non-intoxicated together. The chronic, moderately ill patients on the ward, who are up and about, soon learn how to help in handling the new alcoholic admission. They provide him with reassurance and kindness. They see that he stays in bed when he is likely to injure himself by being up. Thereby they take some of the work away from the nurses and orderlies. Often they help in giving fruit juice and fluids to the patient as he is coming out of his therapeutic insulin reaction. The next morning all are friends and the chronically-ill patient shares some of the nurses' and doctors' satisfaction that comes with seeing someone respond successfully to treatment. In other words the alcoholic is an indirect means of improving the morale of the ward. The alcoholic when not drunk is frequently an extrovert and may be so jovial on recovery that he adds new spirit to a ward whose tone may have been tending towards one of depression.

The general treatment of acute alcoholism has been well established and there are broad principles upon which to base the treatment of the individual patient. A complete physical examination should be done to rule out alcoholic complications or other disease. The finding of a pneumonia cardiac failure or signs pointing towards a latent head injury may affect the treatment to be prescribed. One might try to taper such patients off alcohol slowly rather than abruptly as is usually done. When it has been decided that no complicating factors are present then one usually decides to counteract the alcoholic intoxication by means of glucose and insulin. No immediate treatment will be necessary if the patient is intoxicated in such a fashion as to be nearly asleep or unconscious. Bell's method of using insulin and glucose is most satisfactory. It will interrupt the craving for alcohol and quieten the somewhat unruly alcoholic in a period ranging from a few minutes to a few hours. It provides the physician with an almost infallible means of producing relaxation and sleep. When the physician uses this method he can admit his patient to the hospital with the assurance that the patient will be controlled. The physician need not fear that his patient will disturb the ward, the nurses, or the administration. Bell's article should be consulted for complete details. He has recently altered the procedure and no longer gives Vitamin B complex to obviate the occasional severe allergic reaction. The B complex is given intramuscularly. In brief it has been our practice to give 20 to 30 units of standard insulin along with 50 c.c. of 59 per cent glucose intravenously, and a solution of Vitamin B complex

INVESTIGATION reveals that the goal sought by the alcoholic is euphoria, that blissful sense of wellbeing and power associated with an uncritical self-satisfaction and disregard for the unpleasant factors in reality.

—A. E. Carver, M.D. in *Alcoholism in General Practice*

containing 30 mgm. thiamin and 100 mgm. nicotinamide intramuscularly. This will usually produce drowsiness and sweating in 30 to 60 minutes. When a definite hypoglycemic reaction has been established for 20 to 30 minutes, liberal quantities of fruit juice are provided. As the reaction wears off most patients will fall into a sleep that lasts for several hours. At times a second injection of insulin and glucose or an intravenous infusion of 5 per cent glucose in saline may be required to produce relaxation if not sleep. Occasionally the insulin produces unconsciousness and if so intravenous glucose is used to overcome the hypoglycemia. There is seldom any need to administer sedatives if a satisfactory insulin reaction has been attained. Hypoglycemia and barbiturates do not mix. Together they may prove fatal. Before giving insulin one should always be certain that the alcoholic has not had large doses of barbiturates; and while there is any residual hypoglycemia after therapy, no intramuscular or intravenous barbiturate preparation should be used for further sedation.

Paraldehyde

The mildly intoxicated individual may be quietened by paraldehyde in instances where it is not possible to give insulin and glucose readily. One may use paraldehyde in doses of 4 cc. intramuscularly if there is vomiting or nausea. Patients who can and will swallow may be given 4 to 8 c.c. of paraldehyde. It should be remembered that chloral hydrate and barbiturates are contra-indicated in the acute state of intoxication.

After eight to 12 hours of therapy the patient enters what has been termed the immediate post alcoholic state. In this state he requires continual reassurance and care. He feels tense and "nervous". He has a coarse tremor and "butterflies" in his abdomen. He may have varying degrees of nausea from gastritis. For moderate tension, restlessness and "the shakes" mephenesin is useful. This may be given as mephenesin tabs 2 (1 gm.) four times daily or Mephate (Robins) caps (0.5 gm. mephenesin, 0.60 gm. glutemic acid) four times daily. More marked degrees of uneasiness may require paraldehyde or bromide and chloral preparations. We have had excellent results using paraldehyde 4 c.c. every four hours alternating with bromide and chloral hydrate 10 c.c. every four hours. The dangers of prescribing sedatives beyond the immediate post-alcoholic period cannot be dealt with here. To restore appetite and with some apparent sedative affect, insulin is usually given in doses of 10 units three times a day one half hour before meals. B complex is given by injection for 24 to 48 hours until appetite has fully returned. When there is gastritis, aluminum hydroxide gel will usually relieve the abdominal burning.

Anticonvulsants

The occasional patient who has been drinking for a long time on a restricted diet may appear to be a likely candidiate for delirium tremens after his alcohol is withdrawn. We have found anticonvulsants, especially primidone (Mysoline-Ayerst) in doses of tabs 1 (0.25 gm.) four times daily most helpful in preventing the onset of delirium tremens in patients whom our experience would lead us to suspect as being inclined to this complication. We have again borrowed from the practice of the Bell Clinic with respect to the use of primidone. When there seems to have been a greater than usual chance for the development of delirium tremens we have, over the past two years, given

intravenous and subcutaneous ACTH. We are currently using Duracton (ACTH - Nordic) in doses of five units subcutaneously daily for one to three days. Prophylactic primidone and ACTH have made delirium tremens almost unknown on our wards. If the physician will use these means to prevent the delirium tremens he will find that his hospital will no longer fear that the alcoholic is going to require restraints and extra nursing care some one to four day after he has been taken off his alcohol.

Delirium Tremens

Should the delirium tremens arise in spite of therapy, or in patients admitted to other wards because of infections or surgical conditions where the alcoholism is of secondary consideration then the physician may control them by repeating the glucose and insulin, using larger doses of insulin; or in the surgical cases who have not had anti-alcoholic treatment on admission, he may begin treating the delirium tremens with insulin and glucose. If this fails, intramuscular paraldehyde may be added to the ACTH and primidone program.

Post alcoholic convulsions have been controlled and prevented in our experience with primidone.

Chlorpromazine (Largactil-Poulenc) is a drug that is currently receiving consideration in the treatment of acute alcoholism in some cases. While we have not used it ourselves we have been impressed with the results which have been obtained at the Bell Clinic and at the London Clinic of the Alcoholism Research Foundation. They have used chlorpromazine in doses of 25 to 50 mgm. (tabs 1 to 2) four times a day with encouraging results during the immediate post alcoholic state. Mild sedation has thus been obtained for 48 to 72 hours at the end of which time the drug has been discontinued. Patients with grossly damaged livers have been excluded from this form of treatment. The chlorpromazine has also been found unusually effective in controlling and preventing delirium tremens when it has been used in doses of 50 mgm. intravenously in the same syringes as the insulin and glucose. It must be used when there is coma due to alcohol or barbiturates. Lehmann's article (2) should be consulted by anyone planning to use this drug.

In the light of our three years' experience at St. Michael's Hospital, it is clear that there are many reasons why a patient suffering from acute alcoholic intoxication should be admitted to a general hospital for effective, easily administered treatment.

NEW FILMS AVAILABLE

The following new films on alcohol and alcoholism are available through the N. C. Board of Health Film Library:

In Time of Trouble

Depicts the understanding pastor's role in counseling the wife of an excessive drinker to an acceptance of her own part in creating the stressful situations which contribute to the husband's need to drink. Especially directed toward ministerial groups, but might be used for women audiences.

What About Drinking?

A discussion film for young people designed to bring out the varying points of view about drinking. Excellent for classroom use.

Teach My Child The Facts

(Continued from page 15)

facts about alcohol and alcoholism. She is entitled to know the real facts because she is not going to grow up in a society in which more than 65 per cent of all adults use alcoholic beverages without being exposed to alcohol problems directly or indirectly.

She will see conscientious, home-loving people like her parents drink moderately and socially without causing apparent harm to themselves or others. She will see others, just as conscientious and respectable when sober, become objects of disgust or pity when drinking. She will read of murder and rape and other crimes committed under the influence of alcohol. She will read of these crimes being committed by people who have never tasted alcohol. She will know people whose homes are broken because excessive drinking is a factor, and she will know total abstainers whose homes are broken also.

What Gives?

But tonight the big question in her young, flexible and receptive mind is: What *gives* about alcohol?

If Lucy lived on the other side of town and happened to be a pupil in Mrs. Margaret Copeland's eighth grade class, she would know what gives with alcohol. She would know the facts. She would know something of the chemical properties of alcohol and how they affect attitudes and behavior. She would understand why some people drink and others do not, why some remain moderate, social drinkers all their lives while others lose control over their drinking after a few years. She would learn to recognize the beginning, middle and late symptoms of alcoholism. And perhaps the most important thing of all, she would learn to recognize and fight mentally unhealthy attitudes in herself as a big step toward maintaining her own happiness and freedom from symptoms such as alcoholism.

These teachers work in the same city. Both teach eighth grade classes. Both are obeying the law which requires them to instruct their pupils about alcohol. Both rightfully point out to their pupils that it is dangerous for high school students to drink.

N. C. State Law

Which of these teachers would you choose to instruct your child about alcohol—that is, if you had the choice? Every state in the Union requires that instruction about alcohol be given in the public school system. In North Carolina the law specifically states that "thorough and scientific instruction shall be given in the subject," that, "the State Board of Education shall be authorized, directed and empowered to select, approve, and adopt a simple, scientific textbook, which textbook shall be free from political propaganda, and approved by the State Board of Health and the faculty of the Medical School of the University of North Carolina, on the effects of alcoholism . . . ."

Two years ago the Superintendent of Public Instruction issued a book entitled "Health Education" which includes an excellent guide for public school teachers on alcohol education. It gives the basic facts about alcohol and its physiological, psychological and sociological effects. It tells why it is dangerous for adolescents to drink and how they can be popular without drinking. It offers

an approach to teaching about alcohol that can do more to prevent alcoholism from developing in coming generations than the fear techniques ever did. Fear techniques in alcohol education have never been proved effective.

Prejudiced Opinion

Unfortunately, the school guide on alcohol education is not in widespread use according to the teachers who attended the various summer study courses on Facts About Alcohol sponsored by the NCARP and several colleges last summer. How many of our teachers, we wonder, are as biased and prejudiced as Lucy's teacher, basing their instruction about alcohol on personal predilections rather than on the scientific knowledge specified by law?

Mrs. Copeland attended the first summer study course on Facts About Alcohol at the University of North Carolina in 1951. She heard Dr. Greenberg and Mr. McCarthy of the Yale School of Alcohol Studies discuss the scientific knowledge about alcohol and the modern concept of alcoholism. She heard Dr. Binkley of Wake Forest College discuss the church and alcohol problems. The social, legal, and economic problems connected with alcoholism were reviewed in detail. Mr. Proctor, Executive Director of the N. C. Alcoholic Rehabilitation Program, talked of the efforts being made by the Program to rehabilitate alcoholic citizens and educate the general public toward the ultimate goal of prevention.

She was especially attracted to the idea of preventing alcoholism by helping young people to develop healthy personalities. What she learned at the University of North Carolina that summer together with other acquired knowledge on mental health and her natural love for children has enabled her to do an outstanding job on alcohol education in her eighth grade class.

Concurring with the recommendation of the Superintendent of Public Instruction and other education leaders, Mrs. Copeland feels that there should be no special course in alcohol education. She limits her instruction about alcohol to a five-week period assigned to the subject as a regular science class project. Alcohol education is given no more emphasis than other science projects.

Educational Materials

During the assigned period the pupils study booklets, pamphlets, this magazine, and other educational materials furnished by the NCARP and other sources. They discuss the facts and fallacies about alcohol and gain a remarkable degree of understanding about alcoholism and mental health.

Visiting the class one day near the end of the project I was amazed to hear 13-year-old boys and girls discuss home conditions and personality traits that could very well lead to alcoholism or other emotional illnesses. They spoke of the "school bully" as the kind of boy who feels that he does not get enough attention at home, so he makes others notice him at school through these

SECURING EVIDENCE

IN Rome's early days men under thirty years of age and women of any age were forbidden to drink wine except at sacrifices. Women were sometimes put to death for violating the law. Cato reported that the ancient Romans were accustomed to kiss their wives for the purpose of discovering whether they had been drinking wine.

tactics. They reasoned that since people will not let him get away with this behavior when he grows up he may turn to alcohol to take the edge from his frustration.

They said that the "shy guy" lacked confidence in himself, and since alcohol deadens self-criticism, thereby giving a false sense of confidence, they could see that the "shy guy" is a good candidate for alcoholism.

They had learned that good judgment, the ability to reason, and self-control are among the functions to be adversely affected first by drinking beverage alcohol and that greater degrees of intoxication cause "thick speech", staggering, and unconsciousness.

When asked to discuss the beginning, middle, and late symptoms of alcoholism, eager hands popped up all over the class. "He begins to sneak and gulp drinks," said bright-eyed Carolyn. Pretty Sandra added, "And he lies about how much he drinks." Lynn, Jimmie, Bonnie and Johnny knew other signs of alcoholism, such as: solitary drinking, morning drinking, "blackouts", and benders.

Miss Roberta Lytle, Psychiatric Social Work Consultant of the NCARP, who observed the class with me, was very much impressed with the practicality of Mrs. Copeland's mental health approach to teaching about alcohol. The children had been thoroughly indoctrinated in the scientific concept that alcoholism is a symptom of emotional illness and that the maintenance of good mental health is the best method for preventing alcoholism. During the five-weeks' course the children had learned to recognize attitudes, feelings, and behavior patterns in themselves that were good or bad for their own future happiness and mental health.

In order to focus their attention on any emotional problems they might have and to help them overcome these problems, Mrs. Copeland gave each of them a questionnaire to com-

Inspired by story in INVENTORY visualizing the excuses which alcoholics use to deceive themselves, art students did remarkable job on posters.

plete which they were not required to sign. They were, however, invited to discuss with her privately any problems on which they wished guidance.

Here was a teacher intensely interested in helping her pupils to be happy and whose understanding and knowledge qualified her to be of help to them. Not only did the confidence the pupils had in her enable her to help them adjust more easily to their school problems but she was also able to help them adjust more happily to home conditions. She was instrumental in helping one child and her parents by persuading them to attend a child guidance clinic for professional assistance.

Personal Questions

To the question, "Are you happy at home?" twenty-three answered "Yes"; five answered "No". Asked why they were happy at home, the usual answers indicated that they felt loved and had good mothers and dads. Those who had unhappy home lives replied that their parents fussed at them all the time.

When asked, "Are you happy at school?" the same number of affirmative and negative replies were given, but only two of the negative replies were from pupils who were unhappy both at home and school. To the question, "Why are you happy at school?" the consensus was that they had friends and enjoyed their school work. Those who were unhappy at school said that their schoolmates made fun of them and that others would not play with them.

The question, "Does anyone in your home drink?" brought ten affirmative answers and eighteen in the negative. Eighteen admitted that they had taken a drink and sixteen knew other junior high school students who had taken drinks. Nineteen claimed that they knew someone who was an alcoholic.

Focus On Emotions

Other questions were: How does alcoholism affect the family? Whom do you admire most? What qualities does that person possess that you admire? Do you possess any of those qualities? Who is the most despicable character you know? Why? Do you possess any traits that he or she possesses?

Panel discussions held near the end of the project evoked enthusiastic response. These are some of the questions they discussed at length: How can I be popular without drinking? Why do people drink beverage alcohol? How do most people feel about the use of beverage alcohol today? Why do some people consider drinking a sign of manliness? What can you as high school students do to discourage that idea? Should magazines and TV allow the attractive whiskey advertisements? Why doesn't the alcoholic give up drinking when he learns it is impossible for him to control his drinking? Can we predict which drinkers will become alcoholics? Why is it dangerous to drink and drive? Are drunkenness and alcoholism the same thing? How can alcoholism be treated? How can

ON MOTHERS AND CHILDREN

IF a mother gives the impression that her life is empty except for what her children bring to her, she places on them the burden of making her happy—which is just too much for any child to bear.

—Camilla M. Anderson, M. D. in *Emotional Hygiene*

the alcoholic face his problems without drinking? What is the name of the organization that is working with the problem of alcoholism in North Carolina? Who finances it? Where is the ARP Treatment Center located? What is AA? How does it work? What is the chief immediate danger of teen-age drinking?

We heard the thirteen-year-old pupils of Mrs. Margaret Copeland answer and discuss these questions with the ease and knowledge one might expect only from well-informed adults. Such knowledge and understanding on the part of our young people is the basis, we believe, for ultimate prevention of alcoholism. Through 1954 approximately 180 North Carolina public school teachers—like Mrs. Copeland—have attended the summer study courses on Facts About Alcohol sponsored by the NCARP in cooperation with several colleges in the State. Like Mrs. Copeland, they have been enthusiastic about the possibilities of helping to prevent alcoholism by helping their pupils to develop healthy personalities and by giving them an unprejudiced picture of alcohol and alcoholism.

I would like for this kind of teacher to instruct my children about alcohol. Wouldn't you?

Program Pointers

(Continued from page 3)

efforts to meet this need through its sponsorship of these educational conferences. We hope that we may have the opportunity to serve other denominational groups in the state in planning for similar alcoholism education projects.

The Director will journey to Waynesville soon to participate in still another alcoholism education program of a different type. A newly organized AA group in Waynesville is sponsoring this public education program to which all citizens of the community are invited. This fledgling group, we understand, enjoys the support of a number of community leaders, among them Rev. James Y. Perry, Jr., Rector of Grace Church, who assisted the members in getting their AA fellowship started.

Television Appearance

One of the needs of the human personality, say the psychologists, is for *new experiences*. A new experience for me was my first television appearance recently on Winston-Salem's Station WTOB-TV. Dr. Kelly, Dr. Forizs, and I were invited by the Forsyth County Alcoholism Program to conduct a 30-minute discussion session dealing with alcoholism and the work of the State Program. Ours was one in a series of public service telecasts granted the Forsyth Program by the local station. The station's program

The neurotic—builds dream castles.
The psychotic—lives in them.
The psychiatrist—collects rent from both.

He has a split personality, and neither part is any good.

from *Am. Jour. of Psychotherapy*

ANSWERS TO ALCOHOL QUIZ

1. (c)
2. (b)
3. (c)
4. (a)
5. (c)

1. False
2. True
3. False
4. False
5. True
6. True
7. True
8. True
9. True
10. False

director was very complimentary of our presentation, and others have since written us favorable comments. We were glad to gain this little experience in television work, and we hope that it will be possible for us to use this wonderful new medium for more of our alcoholism education work.

With each day's mail, our file of Yale scholarship applications grows thicker. It has been my observation that each year the average professional level of the applicants rises, and this year is no exception. We are pleased to have received applications from two County Health Officers this year. I was interested in the remarks of both these men in their letters of inquiry. One, whose post is in Eastern North Carolina, said: "I am keenly interested in the Yale School of Alcohol Studies . . . I am frequently being asked for advice and guidance in regard to this subject." The other, writing from fifteen years experience in public health work said, ". . . I feel that alcoholism is an important phase of our total mental hygiene program." It is reassuring to know that these physicians, as busy as they are, recognize alcoholism as a public health problem and would be willing to devote a month to an intensive study of the illness.

The other day, Dr. Forizs and I spent an enjoyable day at the Alcoholic Rehabilitation Center, meeting with a class of ministerial students from Southeastern Seminary at Wake Forest. They were studying the resources of the NCARP as one segment of a semester's study of mental and emotional illness, including alcoholism. Under the direction of Chaplain Steininger of State Hospital, Raleigh this group gets first-hand knowledge of the subject by actually working and studying in several of the State's treatment facilities for the emotionally ill. Dr. Forizs' explanation of the causes and treatment of alcoholism, and mine of the services of the NCARP were received with much interest by the class. We are glad to have a part in the education of these future pastors for what we hope will be a more effective ministry to the alcoholic and other emotionally sick people.

TEN safety signs of good mental health are:

1. A tolerant, easy-going attitude toward yourself as well as others.
2. A realistic estimate of your own abilities—neither underestimating nor overestimating.
3. Self-respect.
4. Ability to take life's disappointments in stride.
5. Ability to give love and consider the interests of others.
6. Liking and trusting other people and expecting others to feel the same way about you.
7. Feeling a part of a group and having a sense of responsibility to your neighbors and fellow men.
8. Acceptance of your responsibilities and doing something about problems as they arise.
9. Ability to plan ahead, and setting of realistics goals for yourself.
10. Putting your best efforts into what you do and getting satisfaction out of doing it.

—Dr. George S. Stevenson, Medical Director
National Association for Mental Health

Books of Interest

MIND AND BODY

3.50

By Flanders Dunbar, M.D.

New York: Random House

HAVING had twelve editions since its publication in 1947, "Mind and Body" has now been revised and enlarged to bring us the latest thinking on the psychosomatic approach to illness. "There is no longer any doubt", says Dr. Dunbar, "that emotional and physiological changes are inextricably intertwined."

She expains lucidly what is involved in the oft-repeated statement that our emotional ills originate in early family relationships. Among these, she lists two dangers: that of "emotional contagion", and that of "exposure to intense adult emotions." She reminds us that a "child's temper is his own, and of itself will not be harmful to him . . . but an outburst of rage in older persons, especially parents and particularly during the first year of life, is a shock which may not be apparent at the time, yet may well be the seed of psychic maladjustment which will grow with the child." Feelings of security, harmony and affection (in moderation), then, are the foundations of a sound mind.

With Dr. Dunbar one begins to comprehend the subtle way in which mind and body affect each other in one of the more troublesome conditions of our age and time—obesity. Obesity is serious, not only because of the mental anguish it causes its sufferers, but because of its real danger to those with heart disease and other circulatory ailments. Persons up to 15 per cent overweight have a death rate 22% above average, those 16 to 25% overweight have a death rate 75% above average. For a long time medicine has tried to pin the blame for obesity on glandular imbalance, but it would now seem that this can account for no more than 1% of the cases. Glands do have an important role to play in maintaining body equilibrium, but if they have been required to make "too many adjustments too early" because of too frequent or too severe physical and emotional demands, even these normally resilient organs can fail.

Disease Prevention

One of the desired trends in psychosomatic medicine is in the development of disease prevention. "Some day there will be courses in high school of psychosomatic studies—just as today there are courses in physiology and hygiene." The concept of the sound mind and the sound body will be taught with real conviction and it will be an accepted fact that "your mind is your body and vice versa."

For those interested in the problem of alcoholism the inference is clear. Readers, lay and professional, will find this an immensely helpful volume.

—Roberta S. Lytle, M.S.Sc.
Psychiatric Social Work
Consultant, NCARP

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

JULY-AUGUST, 1955

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

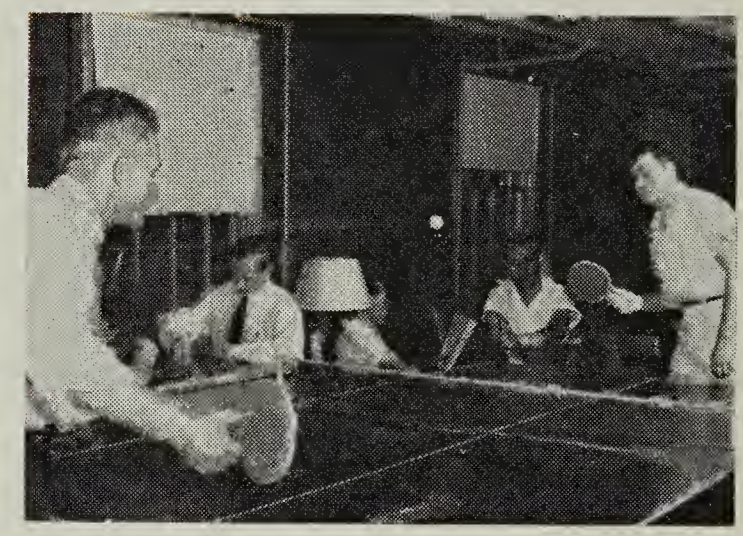
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center has a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME V — NUMBER 2

JULY-AUGUST, 1955

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Proud Of Butner

I am not ashamed that I have been to Butner. I am proud of the fact that the State of North Carolina has provided a place like that for men in my condition. I cannot see how a man that sincerely wants help can come away without it. With the help of God and the things I learned there, I know I can stay sober.

Name withheld

A prerequisite to recovery from alcoholism seems to be a sincere desire to be helped by persons qualified to relieve the underlying tensions which cause the drinking. That is why we stress voluntary desire for treatment at the NCARP Center. That is why AA will not come to a person's aid until that person wants help.

Great Stuff, Says AA

Your *Inventory* publication is doing a real service, not only to your state but through AA in various states. I have used your philosophy and writings many times at (AA) meetings, always with the same response, "Great stuff to make one think."

Name withheld

We are humbly grateful for the opportunity to be of service to AA's wherever they are. The encouragement and support of this Program by AA groups and members has been an inspiration to all of us in our educational work with alcoholics and the general public.

Thanks And Congratulations

Have been receiving your publication *Inventory* the past two years and wish to both thank you and congratulate you. We here in Utah do appreciate very much the help we have received from your program in North Carolina through this publication of yours.

Rex Hughes
Member, Utah State Board
of Alcoholism
Provo, Utah

Compliments May-June Issue

Inventory is usually excellent. Want you to know that the May-June issue was "more so." More power to you.

Rev. Paul E. Whitmoyer
126 College Avenue
Lancaster, Pa.

NCARP In The Forefront

I read with more than usual interest the May-June issue of *Inventory* and particularly the successful fight you have waged changing the attitude of North Carolina hospitals towards accepting alcoholics for treatment. In 1943 when those of us in the *Research Council On Problems Of Alcohol* undertook the study of "Institutional Facilities for the Care of Alcoholic Patients", we discovered an extremely bleak situation. The years immediately following were years fraught with tremendous resistance on the part of a majority of

hospitals to the admission of alcoholic patients. As state programs have come into existence, however, aside from the direct assistance they have rendered to alcoholic patients, one of the really remarkable achievements to which they can lay just claim is the fact they have served as a major educational device for hospitals and communities at large that alcoholic patients are treatable. In this regard, the North Carolina program has been distinctly in the forefront.

I would like once again to extend you my warm congratulations.

Joseph Hirsh
Associate Professor of
Preventive and Environmental
Medicine
Albert Einstein College of
Medicine
Yeshiva University
New York, N. Y.

Dr. Hirsh has long been one of the leading authorities in the fields of alcoholism and human relations. Author of many articles and studies concerning health, welfare, and education, Dr. Hirsh was one of the first to attack public resistance to the concept that alcoholism is an illness. His book, "The Problem Drinker" ($3, Duell, Sloan & Pearce, Inc. New York) is written in language anyone can understand and is an eloquent plea for public understanding of the problems of alcohol.

Calls Mag Acute And Helpful

Thank you for the March copy of *Inventory*. We thought the article, "Alcoholics Are Out of This World" particularly good but I must say the entire magazine is so acute and helpful it is hard to pick out anything for special mention.

Gordon McWhirter
Vice-Chairman
Sacramento Committee on
Alcoholism
Sacramento, California

Pastor Finds Article Useful

I have read the article, "Teach My Child The Facts About Alcohol," which I find useful since I am soon to teach a study course on alcohol to Intermediates in a local church . . . . I agree heartily with Dr. Dicks . . . that the church's contribution is in the field of prevention. I like his analysis of prevention.

Rev. Willis H. Switzer
400 N. Person Street
Raleigh, N. C.

Although the article referred to was written primarily for teachers and parents we are pleased that the ideas expressed are considered useful by the clergy in their work with young people. Dr. Russell L. Dicks, incidentally, is editor of *Religion & Health,* (Subscription $3 per year, Box 4802, Duke Station, Durham, N. C.) which we think is a pretty wonderful little magazine, the purpose of which is "to promote spiritual well-being, and physical and mental health." All persons interested in these goals for themselves and others will find much comfort and guidance within its pages.

Salvation Army Centers

Certainly we were overjoyed to see the article by George Adams on the Minneapolis Salvation Army's Mens Social Service program of rehabilitation. We are enclosing . . . . a thumbnail description of our Men's Social Service program conducted in our Nashville Center. The Nashville Center together with the larger Minneapolis Center are just two of approximately 120 rehabilitation centers in the United States.

S/Major W. C. Young
The Salvation Army
Nashville, Tenn.

Our hats are off to the Salvation Army for its outstanding record of rehabilitating homeless alcoholics, many of whom had given up all hope, period.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

THE Kanuga Conference on Alcoholism held at Hendersonville June 10-12 was a very satisfying experience for those of the ARP staff who were privileged to participate.

Attendance at the Conference, which was sponsored by the Department of Christian Social Relations of the Episcopal Church, was heartening and represented a variety of professional and lay interests. Members of the Episcopal clergy from Kentucky, North Carolina, South Carolina, Georgia were present, as well as a number of Episcopal lay people representing their local Departments of Christian Social Relations. Alcoholics Anonymous was also represented with members from North and South Carolina in attendance.

Enthusiastic Response

The general response of the participants to the materials presented through lectures, films, and in directed group discussions was very enthusiastic. Since we of the ARP are always anxious to improve our role in educational efforts of this type, we asked those in attendance to write their candid criticisms of the entire proceedings—subject material, organization, lectures, method of presentation, etc.

Most of the written comments were favorable and contained helpful suggestions which will be useful in organizing future conferences of this type. Following are excerpts from a few of the remarks.

A layman had this to say: "In my mind this has, by all measurements been the finest conference on alcoholism I have ever attended. It seems to me that in every approach the lecturers have gone right to the heart of the matter without any detours."

Calls Conference Beneficial

An AA member from one of the North Carolina groups wrote, "As an alcoholic, a member of AA, the Episcopal Church and as a citizen interested in the welfare of the community, I believe a conference of this nature most beneficial. My congratulations to the ARP for the splendid way it was handled and the quality of the speakers provided."

After praising the content of the program, an Episcopal clergyman suggested ". . . that the Episcopal Church spearhead a drive for a better public enlightenment on the subject of alcoholism."

The Episcopal Diocese of North Carolina is to be congratulated for undertaking sponsorship of the Kanuga Conference on Alcoholism. Dr. Kelly, Miss Lytle, and I are pleased that we were asked to participate in planning for the conference and in its proceedings. Let us hope that it is the forerunner of similar undertakings by other denominations to disseminate objective and scientific

(Continued on page 31)

VOL. V. No. 2 **INVENTORY** JULY-AUGUST, 1955

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Having a "protector" behind the scenes reduces the alcoholic's desire for treatment.

THE TOUGHEST PATIENT TO TREAT

SOMETIME in the course of his illness the alcoholic may reach a stage when life becomes so chaotic, and the punishments for the excesses so enormous, that this fact in itself becomes a motive for seeking treatment. The pleasures of drinking have shriveled up while the painful consequences have grown to intolerable strength.

A certain type of problem drinker. however, seems never to reach this stage. And because his punishment never becomes unbearable, the motivation to stop drinking does not develop. If he happens to turn up in a clinic for alcoholism, he will be found impervious to the usual therapeutic methods. Careful search will then disclose that some other person is operating behind the scenes in the role of protector. Usually it is a member of the family. The protector acts as a buffer between the alcoholic and the rest of society, rescuing him from scrapes, supplying him with his needs, taking care of him the way a mother would care for her dependent child.

Three such cases recognized at the clinic of the New Hampshire Division on Alcoholism have been described in detail in a report by

D. J. Myerson. One in particular seems representative of a rather large number of alcoholic men.

The patient, a 34-year-old man of middle-class Yankee stock, was the youngest of six children and the only boy in the family. He was only 4 or 5 when his father died. Thus he was raised in an exclusively feminine environment. He was a sickly child, suffering from asthma. On top of these unfavorable conditions, his mother became excessively attached to him. She indulged his every whim and the entire household came to revolve around the youthful dictator.

Real Trouble At Home

In spite of all this the patient had shown enough independence to marry, and for some years operated a successful hardware business. In the eyes of the community he was a hard worker, well liked by both men and women, although he seemed rather vain and self-centered. It was at home that his poorly developed personality made real trouble. For he expected his wife to be another slavish mother. Whenever she fell short of this extreme, he would heap torrents of abuse on her. If this didn't work, a maddening silence would fall over the house for days. By every sort of unreasonable and childish means he tried to dominate the home-scene and his demands were insatiable. His wife, with great difficulty, was able to maintain some sort of balance during the early years of the marriage. But the situation went to pieces with the birth of a daughter.

The patient, all unawares, had been striving to remain the all-powerful infant throughout his lifetime. He could regard this newcomer only as a threat and a rival. As the baby took more and more of her mother's attention, the husband's abuse grew more violent. Although he had been a controlled daily drinker until then, he started drinking to excess. In due course his business began to suffer. The community woke up to the true facts of the situation and turned its sympathy towards the wife.

Mother Protects Him

This might have proved the psychological moment for treatment. With his business starting to fail, his wife and child threatening to leave, his friends turning against him, there were powerful motives for surrendering. But one factor tipped the scales in the other direction. His old mother, now 68, saw her chance to win back the beloved son. From the outset she had resented her daughter-in-law.

Here was the protector behind the scenes. Instead of working to stop her son's drinking, she gave him the money to buy liquor. Whenever he got into trouble, she came faithfully to the rescue. The young wife

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ALCOHOL is not the only impediment to the clearest thinking. Rationalization or extreme emotionality distorts thought, and many a person is more drunk with prejudice, fantasy, or power—less able to think straight—than is many a man at the bar. Whether it flows from the comforting flask or from the natural inability to keep one's head, unrealistic thinking in the extreme triples one's blunders; its cheer is a cheat.

Wendell White, in "Psychology in Living"

Delirium Tremens and Rum Fits

Withdrawal of alcohol can set off symptoms of mental illness, with convulsions and delirium.

DELIRIUM tremens is perhaps the most dramatic illness which befalls some alcoholics. Typically, the patient's body trembles violently, and he sees imaginary things, especially frightening objects such as snakes or rats. He may also hear imaginary voices. Equally dramatic but not so common are "rum fits"—convulsions resembling epileptic attacks. Both these conditions have been seen in alcoholics mostly at the end of a long bout of heavy drinking.

For long years the question has been debated in medical circles whether these acute illnesses are caused by heavy drinking or rather by its sudden stopping after a prolonged alcoholic bout.

Delirium tremens often starts right after an alcoholic has been admitted to a hospital and thus is forced to stop drinking. This has been cited as proof that the condition is a violent reaction to being suddenly deprived of alcohol. On the other hand, delirium tremens has been seen to start in alcoholics while they were still drinking. This is held by many to prove that it is not abrupt withdrawal of alcohol which causes the illness but rather the very heavy drinking itself.

Still other specialists in alcoholic disorders have thought that the cause may be the acute dietary deficiencies which usually go with alcoholic bouts, or perhaps injuries which alcoholics suffer while drunk. Head injuries, in particular, could be responsible for the so-called rum fits.

The answer to this problem is not

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ALCOHOLISM IS INDUSTRY'S HEADACHE

Adapted from the booklet, "A Problem in Business and Industry" by Ralph M. Henderson, Industrial Consultant, Yale Center of Alcohol Studies, and Dr. Selden D. Bacon, Director, Yale Center of Alcohol Studies, New Haven, Connecticut.

There is a workable plan for reducing this painful and costly problem.

MR. Typical Big is head of an industrial plant. It has been suggested to him that his company establish a constructive program for meeting the problem of alcoholism. "What?" he explodes, "We have no such problem in our plant. Alcoholics are unemployable. We don't employ bums, neurotic geniuses, or Lost Weekenders, and I can't see why business and industry should shoulder the stigma and cost of meeting a problem which pertains less to them than to almost any other group." Mr. Big might also feel, though he doesn't say it, that anybody bothering him about such a problem is a blue-nosed, teetotaling reformer; and nobody's going to criticize *his* drinking.

Mr. Big's brother, Hardrock, also runs a large industrial plant. When the suggestion is offered to him he grudgingly admits the remote possibility that there is such a problem in his plant. "But," he says, "Our establishing an alcoholism program would create more problems. Labor, for example, would consider any program as offensive paternalistic meddling. Recognizing the problem would also be bad public relations. In addition, the program would call for extraordinary and expensive techniques and personnel, would result in pampering drunks, and would eliminate the only practical way of handling the few cases that do arise —firing them."

Barriers To Action

Such attitudes on the part of managements form a barrier to constructive action that is extremely hard to overcome. Traditional beliefs are stronger than objective proofs. It is, however, possible to weaken and finally overcome the barrier because, whether it is admitted or not, the results of problem drinking in industry are continuing, painful, and expensive. Secondly, it

has been proved that something practical and effective can be done to reduce the problem.

Deeply neurotic and Skid Row types of problem drinkers form but a tiny segment of the alcoholic population. A majority of problem drinkers who seek treatment are steadily employed, most of them with jobs involving skills or special responsibilities. Three out of four live in established households. Over half are married and living with their wives.

Problem Drinker Defined

The problem drinker in industry can be defined as the employee whose work is materially reduced in efficiency and dependability because of excessive drinking. He is the employee whose drinking excesses are more or less repetitive. He is the employee whose drinking is recognizably affecting his health or personal relations. This is the man who is costing his employer money. This is the man who in many instances can be helped.

It has been conservatively estimated from statistical studies that there are at least 1,650,000 problem drinkers in business and industry. They lose an average of 22 working days each per year from the acute effects of alcohol alone. Each loses annually 2 days more than non-alcoholics because of various other ailments. The problem drinker's accident rate is twice that of the abstainer or ordinary drinker. His life span is reduced approximately 12 years in comparison with that of the non-alcoholic, and economic costs arising from problem drinking among employees are staggering. One of the greatest costs to industry is replacing trained workers and executives dismissed at their productive peak.

Actually, how big is the problem to an industrial concern employing, say, 1,500 people? It should not be

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THE MINISTER AND

To help him recover, the minister must be informed, patient, understanding, and a skilled counselor.

ONE of the most widespread illnesses in the average American community is alcoholism. It has been estimated that around six per cent of all employable males are afflicted with this chronic disease. Known to practically every citizen of a community are lawyers, doctors, salesmen, business men—and women too—whose lives have become unmanageable because of an uncontrollable drinking habit. The minister is one of the community residents who is expected to do something about the alcoholic and his dependents.

Misunderstood And Rejected

In his foreword to Dr. Clifford Earle's book, "How to Help an Alcoholic," Dr. Russell Dicks gives this picture of the problem drinker: "The alcoholic has been described as 'the leper' of this generation. He comes to feel himself an outcast, misunderstood, criticized, and rejected. His sense of dignity sinks to a very low ebb. The one thing he knows is to escape through excessive drinking. To tell him that he is destroying himself is to increase his drinking, for basically that is what he is trying to do. To tell him that he is hurting his family and destroying their love for him is only to increase his drinking, because he feels that

THE ALCOHOLIC

By J. BERNARD HURLEY

MINISTER, FIRST METHODIST CHURCH
LIBERTY, NORTH CAROLINA

he has already disgraced them. To tell him to stop drinking, particularly if you are a significant person to him, is to push him further into alcoholism because you have told him to do that which he cannot. He has lost his sense of selfhood, his sense of being of worth. His one desire is to get drunk and forget it all, and he usually does."

First Approach To Problem

The minister's first approach to a problem of this nature should be the acquiring of as much information as possible about it. In recent years a great deal has been written and said to inform the public of the true nature of alcoholism, and to encourage the proper approach to it. A helpful ministry to those who suffer from alcoholism cannot be realized as long as misinformation, ignorance and prejudice about the subject exist. If it is true as a recent survey indicates that two-thirds of all alcoholics begin drinking in high school and one-third in college, then the minister should feel strongly the obligation to learn the facts of this vast problem.

It is significant that the minister's contacts with alcoholics be friendly and reveal some understanding of

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THE ALCOHOLISM RESEARCH FOUNDATION OF ONTARIO

This is the first in a series of articles featuring the detailed stories of the organization and development of other outstanding programs on alcoholism.

UNTIL about a month ago, officials of the Alcoholism Research Foundation in Toronto, Ontario, prided themselves in the fact that they were engaged in the pioneer alcoholism control program in Canada—dating all the way back to 1949. Then a research worker came up with the news that three-quarters of a century earlier the legislature of the province had passed "An Act to provide for the establishment of a hospital for the reclamation and cure of Habitual Drunkards," and had appropriated $100,000 for the construction of a 78-bed hospital for this program to be completed by 1875. It offered some small comfort to know that this early hospital had to be turned over to the accommodation of the mentally ill before the first "habitual drunkard" was admitted: so the Ontario Foundation, established five years ago, actually offered the first such public service north of the border.

(There are now five provincial programs operating in Canada—the Alcoholism Foundation of British Columbia, the Alcoholism Foundation of Alberta, the Bureau of Alcoholism of the Province of Saskatchewan, the Committee on Alcoholism for Manitoba, and in Ontario, the Alcoholism Research Foundation. There is growing evidence of similar interest in Quebec and the Maritime provinces.)

Research Is Basic

Inclusion of the word "research" in the title of the Ontario organization is deliberate and significant, by the way. The Foundation here is more than a place where victims of alcoholism can and do find treatment; and it is more than a provincial information centre distributing factual data about problem drinking. Treatment and public and professional educational services do form integral parts of the total control program, but basic to both is research—into causes, characteristics, magnitude and implications of problem drinking in our society, and into more effective forms of treatment

Research—into causes, characteristics, magnitude and implications of problem drinking—is basic to this pioneer Canadian program which includes treatment, rehabilitation, and education for prevention.

By R. R. ROBINSON
EDUCATIONAL DIRECTOR
ALCOHOLISM RESEARCH FOUNDATION
ONTARIO, CANADA

and methods of communicating the information and attitudes which will lead, ultimately, to prevention.

That's a tall order; and here is how it is set forth in the official language of the Alcoholism Research Foundation Act of 1949: "The objects of the Foundation shall be and it shall have power: (a) to conduct and promote a program of research in alcoholism; and (b) to conduct, direct and promote programs for, (i) the treatment of alcoholics, (ii) the rehabilitation of alcoholics, (iii) experimentation in methods of treating and rehabilitating alcoholics, and (iv) dissemination of information respecting the recognition, prevention and treatment of alcoholism."

Physically, the Foundation today comprises a head office at 9 Bedford Road, in midtown Toronto, a 15-bed hospital (Brookside Clinic) and an extensive out-patient clinic next door, and branch organizations with out-patient clinics in London and Ottawa. The staff totals 42, including seven part-time general physicians and specialists in psychiatry and internal medicine. The annual budget for the current year is slightly in excess of $225,000. By far the largest part of this budget consists of an annual grant through the provincial Department of Health, with a relatively small share being made up by fees collected from patients.

Many Referred For Treatment

Last year there were 1101 patients using the Foundation's treatment services—636 of them new patients (529 men and 107 women). Among these 636 new patients, the greatest number of referrals came from Ontario physicians (168), the second largest number from Alcoholics Anonymous (109), and the third largest group were referred by family and friends (106). The balance came through other medical services, social agencies, courts, clergy, employers, and other patients.

There are three types of services offered to patients by the Foundation in Toronto—general hospital emer-

gency treatment, Brookside hospital in-patient care, and Brookside Clinic out-patient service. Frequently all three are combined in a single case, although this does not necessarily follow with every patient admitted. Three of Toronto's large university teaching hospitals cooperate with the Foundation by providing short-term treatment on their regular medical wards for acutely ill or intoxicated patients when this is recommended by the screening physician. Such emergency treatment, which includes insulin-vitamin-glucose injections, lasts one to three days; and then, when indicated, the patient is transferred to the Foundation's own small Brookside unit. Here the length of stay averages 11 days, and the course of treatment may include both individual and group psychotherapy. Ideally, then, the patient moves on into out-patient care and he may follow through on a course of weekly interviews and group activities extending over several months.

Former Patients Return

Even after formal treatment has ceased, patients are encouraged to drop into the clinic informally and visit with staff and other patients in the spacious garden and comfortable lounge provided for this purpose. Recently, too, a number of former patients took the initiative and organized an AA group made up exclusively of ex-Brookside men and women, and they are now meeting regularly in a nearby church hall.

Mention of AA brings out another facet of the Foundation's program. A mutually advantageous working relationship has been built up between AA and this organization over the past few years; and one of the evidences of this is found in the practice of permitting the use of the clinic's group therapy room on two evenings each week for the purpose of giving new patients a sample of the AA program. There is no compulsion about attendance on the part of the patient; but a substantial number usually turn out, and many patients have, as a result, moved on into the supportive atmosphere of the AA fellowship after their discharge from treatment. Responsibility for the AA programs and speakers at these meetings is vested in a very dependable and conscientious liaison man.

Group Therapy Important

Group therapy forms an important part of the treatment program at Brookside; and there are two regular groups which deserve special mention. One is under the guidance of Dr. John D. Armstrong, Foundation medical director, and he recently reported on this before the 1955 convention of the American Psychiatric Association in Atlantic City. This group has been meeting each Saturday morning over a period of three years, with an average attendance of 35. Appreciable improvement has been noted in the core of faithful members who seldom miss a meeting. Besides its therapeutic value, this group has also provided Dr. Armstrong and his associate in psychology, Robert J. Gibbins, with a wealth of research material.

Work With Wives

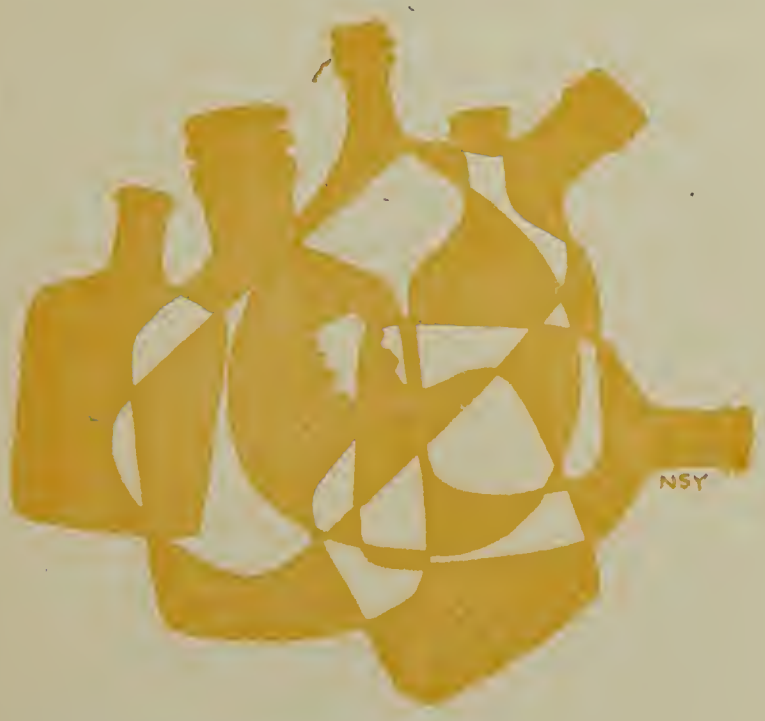
The other group which should be mentioned is under the leadership of Miss Margaret Cork, chief psychiatric social worker, and it is a smaller group made up of the wives of alcoholics (whose husbands may or may not currently be undergoing treatment). Again, a report on this group's activity was presented to the national conference of the American Association of Psychiatric Social workers in San Francisco late in May. On occasion a wife has attend-

ed this group before her husband was ready to accept treatment, and her progress has been sufficient to encourage the husband to come to the clinic himself.

The Foundation branches at London and Ottawa have no in-patient facilities on their premises, but they have arrangements with the general hospitals in their communities whereby emergency care is provided as in Toronto, and they are carrying on active out-patient programs. Both branches employ part-time medical directors and have specialist consultants available; and in both instances the executive secretary has his M.A. in psychology and engages in clinical work.

Expected To Pay

With regard to patients' fees, the Foundation takes the view that acceptance by the patient of financial responsibility for his course of treatment is an important part of the alcoholic's rehabilitation. Consequently, every patient is expected to pay his way—although payment in advance is not demanded, and provision is made for the discharge of indebtedness over a long period if necessary. Charges for general hospital emergency care are at the particular hospital's regular per diem rate, plus the cost of medications, plus a flat $15 per admission to cover the services of the physician-in-charge. The Foundation pays the hospital and then, in turn, bills the patient for this. Brookside in-patient rates are $10 per day plus special medications, and Brookside out-patient rates are now in process of revision in the direction of establishing a flat fee to cover a definite period of treatment.



Grants To Universities

On the research side, the Foundation has been making grants to universities in the province of Ontario since 1951. These have been for specific projects in departments of pharmacology, physiology, psychology, anthropology, and sociology. The fourth annual report, for the year ended December 31, 1954, listed a total of 31 such projects covering a broad range of subjects. The following partial list of 1954 projects may serve to indicate the breadth of the approach: (1) Investigation of disulfiram and other drugs which alter the reaction of the body to alcohol; (2) Study of liver disease in alcoholic patients; (3) The role of alcohol in the cause of metabolic and structural disturbances in the animal organism; (4) Some cultural and social bases of drinking habits; (5) A study of a prison aggression group; (6) Critical study of the possibilities and limitations of the Jellinek Estimation Formula; (7) Studies on the incidence of alcoholism; (8) Drinking patterns in an industrial society; (9) A study of the introduction of alcohol upon the Indians of northeastern North America; (10) A study of the urban tavern in relation to the rates of insobriety and consumption.

In July 1954 a full-time research department was set up within the Foundation to carry forward certain intra-mural work. This is headed up

by a social anthropologist and a psychologist and includes an assistant and statistical clerk. The annual budget for research last year stood at $20,000, and it is hoped that this may be increased during the current year.

The current educational budget also stands at $20,000; but the splendid cooperation of press, radio, television, and National Film Board has made it possible to more than double the value received from such an investment. For example, 35 of the province's 45 privately-owned radio stations last year donated nearly $15,000 worth of time to carry the Foundation's series of 13 quarter-hour broadcasts, "The Secret Illness." The federal government's National Film Board, on two occasions sent production units to Brookside hospital to make (a) a half-hour documentary for the national television network, and (b) a seven-minute, 33 mm. featurette for distribution on a national scale through regular commercial movie houses. And throughout the year, the press, both periodical and daily, has given generous coverage to the subject of alcoholism generally, and to the work of the Foundation specifically.

This has made it possible to invest the bulk of the education budget in undertakings of more modest cost such as newsletters for industrial personnel executives, and parent-teacher association leaders, reprints, folders, and pamphlets designed for other specific segments of the province's five million population. One of the latter that merits special mention is a 16-page, five-times-a-year periodical for physicians, nurses, social workers, and others professionally interested in alcoholism. Circulation of ALCOHOLISM RESEARCH now stands at 13,500 copies per issue and the mailing list is growing steadily.

Key To Basic Philosophy

ALCOHOLISM RESEARCH was the first major educational undertaking of the Foundation, and in this fact lies the key to the organization's basic philosophy. Recognizing that there are, in round figures, 50,000 alcoholics in the province of Ontario, those responsible for Foundation policy felt it was out of the question to think of setting up specialized treatment facilities at innumerable points where they would be readily accessible to a population scattered over more than 400,000 square miles of territory. It was deemed much more practical to think in terms of one central research and treatment centre which would serve the twofold purpose of treating very difficult cases and of developing techniques which could be effectively transmitted to the 6,500 physicians and 171 public general hospitals of the province. The communication of Foundation findings at the professional level constitutes one important aspect of the educational program; and, in addition to printed material specially prepared for this purpose. A great deal of time and energy are expended by staff members in ap-

The judge eyed the culprit menacingly. "You are accused," he said, "by your landlord of being drunk and setting fire to the bed."

"It's a lie, Judge," cried the man indignantly. "That bed was on fire when I got in it."

pearing personally before physicians, nurses and social workers-in-training. Further, the Foundation accepts on a teaching basis for limited periods post-graduate students in psychiatry and in social work.

Educational institutes organized by the Foundation for such special groups as high school teachers, industrial personnel executives, clergy, etc., fill in another part of the picture, as does the participation of staff members—treatment, research, and education—in such conferences as may be organized by other groups with an incidental interest in alcoholism.

In short, the educational program is almost as broad and many-faceted as the problem of alcoholism itself; and the Foundation makes use of every available medium to convey the information and attitudes which, hopefully, will lead the people of Ontario toward the prevention of this medical-social disorder. Every effort is made to keep the education and the treatment programs firmly anchored to underlying realities through honest and energetic research.

"It is through research into causes that the real hope lies for preventive action in the future," sums up H. David Archibald, executive director, "and it is through research on treatment methods that a way can be seen to reducing the burden of the more than 50,000 alcoholics now found in Ontario."

TIPS ON MATURITY

IT is fortunate that most of us are not entirely satisfied with ourselves and our work. If we were satisfied, there would be no growth mentally or emotionally. Because we are not satisfied, we try to improve ourselves so that we will achieve not necessarily financial security but, what is more important, the maturity of the mind and emotions that will make us an asset to the community. The famed psychiatrist, Dr. Edward A. Strecker, lists these eight personality qualities of emotionally mature people:

1. **Sticktoitiveness: the ability to stick to a job, to work on it, and to struggle through it until it is finished or until one has given all one has in an endeavor.**
2. **The quality or capacity of giving more than is asked or required in a given situation. Reliability.**
3. **Persistence is an aspect of maturity. Persistence (like sticktoitiveness) to carry out a goal in the face of difficulties.**
4. **Endurance: the endurance of difficulties, unpleasantness, discomfort, frustration, hardship.**
5. **The ability to size things up, make one's own decision. This implies a considerable amount of independence. A mature person is not dependent, unless ill.**
6. **Maturity represents the capacity and willingness to cooperate; to work with others, to work in an organization and under authority.**
7. **Maturity includes determination, a will to achieve and succeed, a will to live.**
8. **The mature person is flexible, can defer to time, persons, circumstances. He can show tolerance, he can be patient, and above all, he has the qualities of adaptability and compromise.**

The Toughest Patient To Treat

(Continued from page 6)

was blamed for everything that went wrong. When he finally had to appear at the alcoholism clinic, he was a complete therapeutic failure. Protected as well as he was, the staff was helpless to motivate him toward recovery.

For treatment in such cases to succeed, Myerson states, the protector on whom the alcoholic depends for support must become a part of the therapeutic plan. In this case the mother was too old and out of reach to be persuaded to serve the interests of the treatment goals. Interviews with her came to nothing. If she offered her son the smallest resistance, he would punish her with more abuse than she could bear. In any event, it would be uncommon for an elderly person with severely distorted ideas to gain insight into her own faulty role where her precious son was concerned. As long as the mother lived, there was little hope of improvement for this patient.

In Myerson's experience, these male alcoholics with a protector in the background can hardly ever be helped. Success depends upon breaking the patient's dependency on the protector, thus forcing him to face the consequences of his drinking. Certain relationships do not yield to interference, however, because the protector himself is helpless. The protector, unknowingly, is getting a perverse satisfaction from the role he—or more often, she—is playing in the tragedy. The mother-son situation is one that almost never yields.

In another case described by Myerson, the alcoholic had managed to intimidate both his older sister and brother. The sister was a lonely spinster who had never loved anyone but the patient. It made her desperately unhappy to refuse him anything. The older brother gave in to him also, but from a different motive: His job made him fear exposure of his brother's alcoholism. The patient managed to manipulate the two relationships so that he was always taken care of. When family finances became dangerously depleted, he tried working on the sympathies of the alcoholism clinic staff.

Sister Cooperates

The clinic plan was to work with the sister in the hope that, with less protection and more punishment, the patient might develop some incentive to meet his own problems for the first time. The sister did not refuse to cooperate; on the contrary, she accepted the project with approval. But the pressure from her alcoholic brother was too great. "He barraged her with letters, pleas

NO prevention of neurosis or crime, no stable marriages, no steadiness and enjoyment of work, no healthy nation is possible if children are not permitted to develop fully to emotional independence and self-reliance.

—Leon J. Saul, M. D. in *Emotional Maturity*

and then insults. It was too much, and finally she told us that his rage made her so guilty and depressed that she had to give in. The two have continued along their previous unfortunate way.

Only the last of the three cases detailed by Myerson resulted in real improvement. This was the situation of a dependent, demanding man married to a woman 9 years his senior. She was a vigorous, masculine person—extremely domineering. Yet these traits were tempered by insight and intelligence.

Wife Forced To Take Over

The patient rebelled against his wife's domination, but at the same time he put her in a position where she was forced to take over the male role. As his drinking problem grew worse, she gradually did everything for him. After several years of this life, her patience came to an end. Exhausted and desperate, she sought expert help.

The outlook was better in this situation because the woman had great strength of purpose and understood exactly what was required of her. Although the husband put her through grueling ordeals in an effort to restore the old dependency relationship, she stuck to her guns. In this she was supported by the clinic psychiatrist, who treated her rather than the alcoholic husband. When the patient eventually realized that she was going to remain firm, improvement slowly began. Perhaps because he felt so drastically threatened and forced to face the consequences, he gave up alcohol. After a year of active treatment of both marital partners, it was clear that the hostility between the two had abated. Even more significant, the man had assumed a good share of his masculine responsibilities and his wife was acting more like a woman.

Although this type of alcoholic men present an especially difficult treatment problem, some of them can be helped. The only source of hope, Myerson states, is to deal with the person who plays the role of the patient's protector. If she can be persuaded to cooperate, then she will need support through a long and difficult battle. But unless the therapist sees that this protector is the one who wields the decisive influences, he will not be able to mobilize the patient's desire to recover.

The Minister And The Alcoholic

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the problem. This is the case because such contacts make for an atmosphere conducive to confidential conversation. Upon being a good listener, the minister will thus be able to determine whether the alcoholic is willing to accept assistance. If it is discovered that the alcoholic insists that drinking is no personal problem, the minister must realize that for the moment there is no help he can render unless, of course, it is an emergency situation requiring hospitalization for an acute condition. In such cases, the minister may thoughtfully assist the family or the alcoholic to meet the emergency. This may lead to a more

profitable conversation when next the minister and the alcoholic meet.

Alcoholism is an ailment, and an alcoholic should be treated with regard for his illness. One should not be unfair in dealing with him. The will to be made well cannot be imposed on him from the outside. The desire must be inborn, for external coercion usually makes the situation much more difficult. He recovers from his illness in proportion to his willingness to recover. If the situation suggests it, a word along this line might be helpful to his dependents. It should be emphasized that the alcoholic is suffering from one of the most prevalent chronic illnesses of the present age. To deal with him simply as a moral failure is ineffective because an approach is based on a misunderstanding of the nature of his problem.

Sympathetic Understanding

He should be treated as a sick person rather than a sinner. Instead of reprimanding him for this mistake of his habitual drunkenness, he should be given sympathetic understanding. He is drinking not because he likes its taste or because he wants to get drunk. He is drinking rather because it is smart, socially acceptable. He likes its effects as a relief from tension, an escape from reality, and a crutch upon which to lean. This, of course, is a part of his illness, and alcohol becomes the momentary relief. It is of no less importance to suggest that through an understanding of the conditions which contribute to his problem plus the insights of a psychiatric, medical, and religious nature, he may recover.

Spouse May Have Problem

The minister will often find that the wife or husband of a problem drinker has some emotional defect. Such a condition may be a contributing factor to the alcoholic's problem. Naturally, to discover this would require some attention on the part of the minister. If he felt unprepared to offer any assistance, then he should be helpful in arranging for the person to consult one who might give proper treatment. Continued consultation is usually helpful after the alcoholic partner has earnestly attempted to bring his life under control.

There is always the question of whether the minister should go directly to the alcoholic to "straighten him out." This approach usually brings harmful pressure and prolongs the making of a decision to seek help. Neither the family nor minister is wise to assume this atti-

SUBSTITUTES FOR ALCOHOL

GOOD companionship serves many of the ends furthered by a quaff of ale, and without dulling judgment. Similarly, a walk should wash away much of the dust of everyday life. A bask in the sun gives you that hard-to-beat feeling of relaxation. The outdoors also puts you to sleep without leaving you groggy in the morning. A good book not merely drowns your troubles; it lifts you right out of them into something satisfying. When you lay it aside, your recollection of your worries has a lot of competition in the forefront of your thoughts. A hobby may cure a worry, but whiskey never does so. The one universal sedative that always has desirable side effects is a congenial occupation.

Wendell White, Ph.D in "Psychology in Living"

tude or make this approach. As a matter of fact, the alcoholic does not need to be reminded of his condition and its likely results. He is already more aware of this than the person trying to recount the complex problems, although he is not likely to make such admission. It is recommended to the minister and to all who would earnestly help the alcoholic, to make quiet, friendly contacts, revealing a depth of genuine compassion and understanding regarding his problem.

Counseling Techniques

When the minister and alcoholic have come together to discuss the problem of alcoholism, it will be necessary for the minister to utilize all counseling techniques at his command. A word of caution—anything of "rejection" should be intentionally avoided. The objectives of the minister in the moments of an interview are: (1) to assist the alcoholic to understand his own feelings, (2) to create a healthy relationship, inspiring the alcoholic to feel kindly disposed toward the minister. When this relationship has been established the alcoholic usually talks somewhat freely about himself. He will often have some extremely derogatory things to say of himself, but the wise minister will readily point out that he is not as bad as he pictures himself, and then proceed to mention some of his sterling qualities.

Use Of Prayer

To encourage the alcoholic to seek treatment is a skill of counseling. It must be done so that the patient will recognize his need for treatment and care. The question arises, "Shall a prayer, or a reading of Scripture, or another item of a devotional nature be offered for the purpose of helping the alcoholic with his decision to seek help?" No minister with any experience will attempt to deny the value and the help of various religious practices in many such cases. It usually helps to remind the alcoholic that there are religious resources for successful living. The alcoholic who has made a fresh start, but who is suddenly overtaken by a period of intense temptation, often finds a new source of strength in prayer. One who does this has an infinitely greater chance of success in his struggle than the man who, without faith and without supernatural help, is fighting it out alone. Every day there are men in the various stages of problem drinking who upon turning their lives over to God achieve victory. Perhaps it may be wise to say there can be no fixed rule regarding the aformentioned question, and the decision in each case will depend largely on the alcoholic, the situation, the family, and the minister's best judgement. It is always appropriate to reassure the alcoholic that God enfolds all His children in His love and that nothing can separate a person from the mercies of God.

The surrendering of his life for treatment is a tremendously big

step for the alcoholic. This means giving up the bottle, something which has been a great crutch in his life. To him the future looks dour and barren without it. But the "battle with the bottle," which has been in progress on the terrain of his immortal soul, must be won—his life must be liberated from all that is detrimental to his entire being. But before he can follow through with his best intentions, another "binge" may occur. This tends to discourage the minister, but let him take heart because this final "spree" may be just the one needed to enable the alcoholic to negotiate successfully that wide chasm which might forever prevent his recovery, for alcoholism is a disease that has either death or insanity as its end if it is not treated and arrested.

Referral For Treatment

Assuming that the alcoholic is ready for treatment, the minister is faced with the problem of referral. Where shall he be sent for direct treatment of his condition? Naturally, this depends on resources available in the community. Some communities have state-governed clinics where alcoholics are given treatment. Other agencies available are general hospitals, private sanitariums, state hospitals, and private treatment centers. In the average community, however, perhaps the local practitioners of medicine, groups of Alcoholics Anonymous, and ministers are about the only sources of help. Whatever help is available, the problem drinker must begin with medical care. He must be sober and in a fair degree of health for other care to have its best opportunity.

Perhaps the next step may be totoward AA, an informal fellowship in which members share their experiences one with another. Stories of recoveries as told by its members are challenging, strengthening, and highly inspiring. Membership in this group is open to any alcoholic who has an honest desire to stop drinking, and its purpose is to help people stay sober so they may stop drinking and learn how to become better managers of themselves. Every minister should acquaint himself with the program of AA.

Continuing The Contact

When an alcoholic desires to receive treatment in a hospital or an alcoholic center, the minister might visit him if such is in keeping with the policies of the institution. Letters of encouragement should be written, as alcoholics enjoy receiving mail. This becomes an effective contact, as does the minister's willingness to drive the patient to and from the treatment center. When treatment has been administered and the alcoholic has returned home, the minister should keep in touch with him through visits and occasional letters of appreciation, encouragement and commendation. The maintaining of his sobriety is a hard struggle—and only those who attempt it know anything of its bitterness. Churches are becoming more sensitive to their responsibility in this area of great need. The minister will prepare his people to receive such needy individuals, and assist the community in the part it can serve in the alcoholic's continued improvement. As numerous ministers know, alcoholics who have some understanding of their problem and are trying earnestly to keep it under control, usually make very fine church members.

One should not forget that there is always the possibility of a relapse. When it comes, one may feel that all the time, money, effort, and patience have been wasted. But this need not disturb the minister too

greatly, as he can help the family to be more objective about the relapse. He must encourage the family and patient to be hopeful and to talk with a therapist to see why it occurred. It is altogether possible that out of such an experience there may be realized a higher degree of harmony within the alcoholic's life, a deeper understanding of the problem, and the family may find one another more pleasant to live with. By all means be patient, not sentimentally soft, but understanding and just; understanding because when a man falls one must remember the many times that he has successfully resisted. And just; because when he does fall, the force of the old temptation has been so great that even you yourself—had your feet been set in slippery places—might not always have been able to stand upright.

Getting back to the part the Church may serve in an alcoholic's recovery, perhaps a series of services such as the one now being conducted in the church served by the writer would be helpful. Realizing the need for better community understanding of the problem of alcoholism as well as something of a therapeutic value for alcoholics, a program by the title, "Alcoholism, Mental Health, and Religion" was inaugurated. Such topics as "What is AA?," "The Effects of Alcohol on the Human Body," "The Emotional Make-up of an Alcoholic," "A Social Case Worker and the Alcoholic," have been presented. Distinguished speakers, educational films, and open forum discussions have been featured on each fourth Sunday evening during the past six months. The response has been most encouraging both on the part of alcoholics and citizens of the community who simply desire more information on the subject. Alcoholics from neighboring cities and counties have attended these services almost as regularly as they attend their AA meetings. The staff of the Alcoholic Rehabilitation Center at Butner has been most helpful and cooperative in the entire program.

May Be Criticized

Upon remembering that the native concern of Christianity is to help people in their time of need, no minister will want to take lightly his preparation for service in the field of alcoholism or his many opportunities to render help. Since there are those who have little understanding of the nature of the alcoholic's problem, the minister may receive some rather irritating criticism for not "forgetting the drunks and allowing them to take care of themselves." The headaches and heartaches may be numerous, and at times one may feel like organizing an adult nursery for certain of his critics, but he must never forget that the most unpleasant of all experiences connected with his ministry to those afflicted with the disease of alcoholism are compensated in the knowledge of an alcoholic's improvement.

Delirium Tremens And Rum Fits

(Continued from page 7)

just of theoretical interest. It is vital for establishing the treatment of choice for alcoholics acutely ill after prolonged periods of intoxication. Is it safe to withdraw alcohol from them, or should they be supplied with it, in gradually smaller doses, to prevent the outbreak of a mental illness?

In the hope of solving this problem finally, a carefully controlled experiment was undertaken by H. Isbell and his colleagues at the Public Health Service Hospital in Lexington, Ky.

Ten Volunteers

Ten former morphine addicts volunteered for the experiment after its purpose and method were thorougly explained to them. All of them had been diagnosed as having a "character disorder" or an "inadequate personality." Their personality defects, however, were believed to be no greater than those frequently observed in alcoholics. None of them had ever had convulsions, and all had normal brain waves as tested by the electro-encephalogram. Seven had histories of excessive drinking, either before they became addicted to morphine or during periods of abstinence from the drug. Their ages ranged between 26 and 45 years.

The experiment was divided into three main parts: In the preliminary period each subject was given a variety of tests, medical, physical, psychological and biochemical. In the second period the subjects drank measured amounts of whisky, designed to keep them in a constant, moderate degree of intoxication: They were expected to show slight unsteadiness in walking and some slurring of speech, but not to have any difficulty in rising from a chair, for instance. The intoxication period was maintained for several weeks, after which drinking was abruptly stopped. What happened to the men in the third period—that of abstinence—it was hoped, would answer the question whether withdrawal of alcohol could cause convulsions, delirium, hallucinations, and other signs of mental illness.

Under Constant Supervision

During the entire experiment the volunteers were supervised 24 hours a day by trained attendants who had no other duties to perform. Their intake of alcohol during the intoxication period, as well as all the food they ate, was carefully measured. Their degree of drunkenness was estimated three times a day. Blood alcohol tests were made repeatedly by means of the Alcometer. Detailed notes were kept on their general behavior. Medical and psychological tests were repeated. Their diet was designed to furnish ample nutrients, including vitamins, so that whatever developed after withdrawal of alcohol could not be due, even in part, to nutritional deficiencies. The at-

WHEN I was a boy of fourteen, my father was so ignorant I could hardly stand to have the old man around. But when I got to be twenty-one I was astonished at how much he had learned in seven years.

—Mark Twain

tendants saw to it that each subject actually ate the prescribed amounts. of foods and vitamin supplements.. Alcohol, as whisky, was given every 2 hours during the day. Additional drinks were given throughout the night to maintain the desired blood alcohol level.

No two men drank the same quantity. Some drank amounts considered to be the maximum possible. Four consumed a little more than a quart of whisky a day. One man, Al, drank as much as 23, 23.5 and 21 ounces of alcohol on 3 successive days in the second week of the experiment—equal to about a quart and a half of whisky a day. Later his intake fell to less than 14 ounces of alcohol daily.

Three Dropped Out

Three men voluntarily dropped out of the experiment after 7 to 16 days. When they stopped drinking they became slightly tremulous, perspired a great deal, complained of upset stomach, nervousness and weakness. All three recovered quickly, however, and in 3 days appeared normal. The other seven continued to drink enough whisky to stay intoxicated for periods running from 34 to 87 days. Their behavior varied: some were boisterous and playful, some irritable and inclined to fight, some morose or depressed. Some of them started out by being happy and active but later became depressed or sleepy. The behavior of Al, who made the highest daily drinking record and continued drinking the longest, was usually well controlled.

When alcohol was discontinued, after 87 days of drinking, Al became nervous and sleepless. Trembling began 8 hours after the last drink. At night he "saw" detached heads and dwarfs, but he realized that he was having hallucinations. He improved soon and after 10 days appeared normal. Tom, who drank for 34 days, also became tremulous after alcohol was stopped. He slept poorly and perspired a great deal but recovered quickly. For the next 10 days he appeared depressed, but then returned to normal. The remaining five volunteers displayed more severe effects. In most of them the symptoms of withdrawal started about 8 hours after the last drink. All but one "saw" nonexisting things and "heard" imaginary sounds. All suffered from inability to sleep.

Withdrawal Symptoms Appear

Jack, who had been intoxicated for 78 days, began to show withdrawal symptoms 12 hours after his last drink. His sweating and trembling were severe and became progressively worse. At night he saw imaginary creatures, with whom he had to fight, and he heard unreal voices. He improved after 3 days but continued to hallucinate from time to time. His condition became normal 15 days after alcohol was withdrawn.

Charley also remained intoxicated for 78 days. Twelve hours after his drinking was suddenly stopped he became extremely weak and felt nauseous. He had a severe convulsion, followed by six more in the next 28 hours. His temperature rose alarmingly. He was then treated with barbiturates in gradually reduced doses. In addition, he received antibiotics, adrenal cortex extract, fluids and aspirin. As he improved, his

stupor gave way to hallucinations. He did not recognize the physician and spoke incoherently. It was 6 weeks before his physical and mental state became normal.

Slim remained intoxicated 55 days and began to show withdrawal symptoms 8 hours after his last drink. Weakness, perspiration and inability to sleep became progressively worse. Although he did not sleep all night, he had no hallucinations. He began to improve after 6 days and thereafter recovered rapidly.

Had Convulsion

Junior drank for 48 days. He became very weak 15 hours after his last drink; at that time his blood alcohol had gone down to zero. He knew where he was and recognized the doctor, but he kept seeing things which were not there. He did not sleep during the first night of abstinence but seemed to improve the next day. In the afternoon, 41 hours after his last drink, he had an epileptic type of convulsion. On the following day he was able to eat and thereafter improved rapidly.

Eight Hours After Withdrawal

Tony's drinking period also lasted 48 days. Eight hours after his last drink he was still intoxicated, joking and singing. As the hours passed he began to tremble increasingly, became weak, perspired freely, and vomited. He was confused and unable to sleep during the first night of abstinence. He seemed to improve later but on the third day began to have vivid hallucinations and trembled violently. He was still extremely agitated on the morning of the 6th day and his temperature was rising. Treatment with barbiturates was then started. He improved rapidly and was normal 14 days after alcohol was withdrawn.

What inference can be drawn from the results of this study? Do they offer a definitive answer to the question whether alcohol withdrawal causes the acute mental illness sometimes seen in alcoholics at the end of a long bout? All the volunteers who stayed drunk for at least 6 weeks showed the characteristic symptoms of alcohol withdrawal: trembling, sweating, weakness, nausea, vomiting, diarrhea, exaggerated reflexes, elevated blood pressure, slight fever and disturbed sleep. Two of them had convulsions. Two had hallucinations. Another two had frank delirium tremens. Isbell and his co-workers do not think that their experiment solves the problem entirely. The results strongly suggest, they state, that withdrawal of alcohol can start a typical chain of symptoms of a mental illness, with convulsions and delirium. But it cannot be ruled out that the symptoms would not have occurred if the men had continued drinking. It seems fairly certain, however, that nutritional deficiencies were not responsible. All the men in this experiment ate a more than adequate diet every day and, in addition, received massive vitamin supplements by injection as well as by mouth.

Even While Drinking

The results show also that delirium tremens and convulsions may occur in alcoholics even while they are still drinking. This happened in the case of Jack, who had been drinking nearly a quart of whisky a day for 6 weeks. On the 43d day he developed hiccups and, hoping to relieve them, reduced his hourly drink by half. After 12 hours he became tremulous and had horrible nightmares and hallucinations. He was able to resume drinking at his regular rate the next day, whereupon these symptoms disappeared. Thus it seems that withdrawal symptoms

may develop while a man is still drinking large amounts, such as a pint of whisky a day, if he had previously been drinking even more. The reduction of the dose, causing a lowered blood alcohol level, seemed to have started the withdrawal symptoms. In some of the other volunteers, too, the symptoms began before all the alcohol had disappeared from their blood.

Practical Application

What is the practical importance of the finding that sudden withdrawal of alcohol may bring about convulsions and delirium? Should alcoholic patients at the end of a bout be given drinks in gradually reduced amounts, producing a slow rather than an abrupt withdrawal? Isbell and his co-workers do not consider this necessary. They believe that alcohol is not the best drug for the prevention of delirium or convulsions. "Its length of action is short, the margin between the doses that produce excessive drunkenness and sobriety is quite small, it causes gastric irritation and furnishes calories devoid of proteins, vitamins and minerals. For these reasons it is probably better to substitute another drug for the alcohol." They recommend, instead, sedatives in amounts sufficient to induce a mild intoxication or sleep at the beginning of treatment. The dose should then gradually be cut over a period of 12 to 14 days. Traditionally, paraldehyde has been used, with various barbiturates and chloral hydrate as second choices. Aside from sedation, the fluid balance should be maintained, nutritional deficiencies should be prevented or treated actively if present. "Actually the only difference in the treatment outlined here, from that most commonly used, is the greater amount of sedation during the first few days of treatment."

Alcoholism Is Industry's Headache

(Continued from page 9)

too difficult to estimate. If 65 per cent of the total U.S. adult population use beverage alcohol and about 6 per cent of these are problem drinkers, we can apply these percentages to the number of employees and figure that there are between 58 and 60 problem drinkers in the plant.

They will represent all departments of the business from top management down to the lowest paid employee: supervisors, salesmen, accountants, stenographers, inspectors, etc. As a rule these employees do not go on extended benders. They have not lost *complete* control over their drinking. They may drink heavily one or two nights during the work-week and report for duty the next day with terrific hangovers which they have learned to "cover up." They tough it out the whole eight-hour workday, but for all practical purposes they might as well have stayed at home. In addition to the 22 working days they will be absent from the job they may spend as many as 40 days on the job during the year in no condition to work effectively because of the after-ef-

THERE are no big moments you can reach unless you've a pile of smaller moments to stand on.

—Lillian Hellman in *Autumn Garden*

fects of intoxication. This makes them not only a problem but a liability to the company.

This is how the problem drinker in business and industry operates: Take Herbert, for example. It is Monday morning and he has to go to work. He doesn't feel like it, but he has to go anyway. He's already been "sick" four Mondays and eight other times in the last six months, and he knows the boss might suspect something if he stays home too many Mondays.

Relieving The Hangover

A few of the 60 problem drinker employees in Mr. Big's plant take "eye-openers" the morning after the night before. Herbert is one of these few. He has learned, as all problem drinkers do if the alcoholism is allowed to progress, how to relieve the pain of the hangover quickly and easily. He simply takes a drink on arising, sometimes before he even attempts to get out of bed. The neutralizing effect of the morning drink won't last long, but at least it will enable him to get to work. In an hour or two his liver will have oxidized practically all of the alcohol, and with the aid of a mouth wash or chewing gum the whiskey odor on his breath will probably not be detected. The hangover will then return in all its intensity but Herbert will be on his feet.

Only Half A Man

Herbert is on his feet all right, but what is happening? His torso, arms and legs go through the familiar motions. But only half of Herbert is on the job. His ability to discriminate between different pieces of material, his accuracy in noting the refined tolerance measure, his flexibility in physical balance and timing—all those abilities beyond dull routine exertions did not come along to the plant.

The scrap pile is larger than usual and Herbert's production is lower. He seems to be spending a great deal of time at the water cooler, gazing dully out the window or hopefully at the clock.

This day which Herbert has spent as a half-man at the plant will never appear on the record under the headings of absenteeism, accident, excessive waste, significant error, low output, or anything else. His supervisor probably suspects nothing, and if he does, will say nothing about it. Why? Because it would upset personal relations and morale; because it would mean extra work, worry, perhaps hearings; because the company is not presently willing to do anything positive and constructive. All it can do is fire Herbert, fine him, bawl him out, or take any like action which will usually make Herbert worse, not better. Not only is Herbert a half-man; he is a hidden half-man.

Many companies confuse drinking with problem drinking and problem drinking with drunkenness. While it is true that all alcoholics get drunk, not all people who get drunk are alcoholics.

Herbert differs in several ways from the non-alcoholic who may have on occasion gone to the office or shop with a hangover. The problem drinker does not simply make a mistake and foolishly drink too much. For him, the experience is just one sample of something much bigger,

something he can't effectively explain or control, something to be feared far more than an isolated indiscretion. He suffers a deep feeling of guilt and remorse about yesterday's drinking that is unknown to the non-alcoholic. It relates to his perception of his whole personality.

The Morning Drink

Because the problem drinker cannot afford too much absenteeism, he will report for work unless the hangover renders him absolutely helpless. He will cover up, "tough it out" on the job. As it becomes increasingly difficult for him to get out of bed and go to work he desperately turns to the morning drink, or drinks, to help him do this.

Almost as costly to the company as Herbert, the hidden half-man, is Polly, the hidden half-woman. Polly is a total abstainer, but she too is one of these "half-persons." Her husband or brother or father or other resident in the home is an alcoholic. When he is on a binge or shaking himself out of one Polly gives little more than lip-service to her responsibilities at the company.

The Real Reason

Problem drinking or alcoholism will not appear on the record as a major or minor cause of her absence, her leaving in the middle of the work-day, her anxiety, her distraction, her mistakes, her inept public relations, but there is no doubt that problem drinking is the real reason. Information, understanding, advice and plans on what to do, relief from stigma, awareness of community resources—all these would increase the effectiveness of this half-worker as much as would a program for an employee who himself or herself was the problem case.

Yet this half-man or half-woman does not present an insoluble situation. In any company it is actually a small number of individuals from whom a large proportion of problems stems. This number can be determined. Steps which have been proved effective can be taken by the company to reduce problem drinking without endangering employee relations. In fact, companies which have established constructive programs report that the employees are invariably grateful for management's understanding attitude and helpful guidance. With proper education and treatment the individual worker whose drinking is beginning to be a problem to him and the company need not let his drinking get out of hand, need never reach the advanced stages of alcohol addiction.

Constructive Approach

The Yale Center of Alcohol Studies has developed a constructive approach to the problem for industry. The cost of the Plan is well within the reach of any concern, whether it employs 100 or 10,000 people.

The purposes of the Plan include discovery of the nature, extent and cost of the problem, the development of means to determine what proportion of those affected can be helped economically; provision of means for rehabilitation; and the development of effective methods for discovering cases in earlier stages and at the time of employment.

Program Of Education

A most important step in realizing these purposes is a program of education to change existing attitudes toward alcoholism and the problem drinker in the environment where he works. When management, supervisors, and the workers themselves develop a more sympathetic understanding of the plight of the problem drinker, then the biggest hurdle has been cleared. The problem drinker—

the hidden half-man on the production line—will come forward, if he knows that he will receive sympathetic understanding and that his case will be given consideration as a medical disorder.

The Yale Plan is not pointed at drinking itself; individuals naturally resist the attempt to interfere with their personal drinking prerogatives. The treatment of a problem drinker does not involve controversial entanglement in any of the "wet" or "dry" philosophies nor is it effective to resort to "preaching," exhortation or the use of scare methods in reaching a satisfactory solution to the individual's problem. The Plan should not become a device for gathering evidence to be used in disciplinary action within an industry. It should be kept on a level above the reach of ridicule of any kind.

Flexible Plan

The first step in the establishment of a program is to develop an understanding of the problem among those in management. Administrative and clinical personnel of the N. C. Alcoholic Rehabilitation Program will meet with the top management of any North Carolina business to describe the problem of alcoholism in industry in detail and to help the company form a constructive program. Because of the many differences between business concerns: nature of the work, number of employees, and existing facilities, plans must fit the company involved. The Plan is extremely flexible but it has been found to work successfully for all types and sizes of businesses.

In general, existing departments of the plant or office can be assigned responsibility for directing the program. Next, a responsible person with administrative ability, experience in employee counseling, and adept at presenting ideas can be appointed to supervise the program. Educational material on alcoholism can be supplied him by the NCARP and his attendance at one of the specialized sessions of the Yale School of Alcohol Studies would give him further training.

He would then be in a position to mobilize existing plant facilities and coordinate available plant assets for getting the program in operation quickly. His knowledge and understanding of the community resources available would enable him to get the program underway with a minimum of expense and trouble. These resources would include community welfare and social groups, clinics, hospitals, the courts, clergy, and last but not least, Alcoholics Anonymous.

Next on the program, as the new conception of the nature and extent of the problem emerges, would be the development of a constructive plant policy concerning severance, discipline, retirement, job replacement, treatment and rehabilitation. With the program and company policies established, the caseload will increase. It will increase because of the confidence the employees will have in such a program. The Allis-Chalmers Company, for example, carried only 70 problem drinkers on its program at first. Today, it carries some 300.

Education about alcohol and alcoholism is a most important part of an alcoholism program in industry. This education must start with top management and extend gradually through the ranks of supervisors, foremen, and the workers themselves. The trained person in charge of the company program on problem drinking can take over this work after management has gained the necessary knowledge and understanding.

The NCARP can help with talks, motion pictures on problem drink-

ing, and selected reading material. Leaflets, pay envelope stuffers, posters, and brief articles in company publications can be used profitably to introduce ideas of prevention of alcohol addiction, and to bring about acceptance of treatment by those already suffering from the illness.

When the employees are assured of the honesty and efficacy of the company's program, the "hidden man" will come forward. No problem drinker wants to develop into a full-fledged alcoholic who drinks to live and lives to drink. Understanding, interest, and help on the part of his employer can keep him out of the ranks of chronic alcoholics and increase his worth immeasurably to the company that employs him. But until business and industry realizes this and takes constructive steps to overcome the problem, the problem drinker employee will remain hidden and will continue to be one of industry's biggest headaches.

Program Pointers

(Continued from page 4)

information about the illness of alcoholism and its accompanying problems.

After long and careful consideration by the scholarship committee, twenty-four recipients out of more than sixty applicants have been awarded scholarships to the Yale Summer School of Alcohol Studies. Scholarship holders have been chosen with an eye to variety of professional backgrounds, geographic location, and potential scope of influence in their communities. Among the group chosen are 3 health educators, 5 social workers, 2 physicians, 5 ministers, 7 supervisors of instruction, one representative of industry, and one college instructor in health education. We realize that in striving for a balanced distribution we have had to pass over some well-qualified applicants, but we want to encourage them to apply for a scholarship again next year.

At this writing, we are closing out our fiscal year and the biennium. We find that our biennial appropriation will show a small surplus which will be returned to the General Fund. This small surplus should not be taken to mean that these funds could not have been used to good advantage in our work. It does mean that the ARP, as an agency of State Government recognizes its responsibilities to the taxpaying citizens and to the principles of good management. Every effort has been made to conserve our financial resources that we might do our share toward government economy, and at the same time carry out our clear duty to the State's alcoholic citizens.

Has Reached Its Limits

An examination of the past two year's activities and expenditures makes it obvious that the ARP has reached its limits in terms of expanded services. The organization staff has been overly taxed, and the amount of time and work they have devoted to the Program's activities is beyond the proportion of money expended. This could not have been accomplished had we not been blessed with personnel who have shown unswerving loyalty and devotion to our cause.

We must face the fact that it will not be possible to further increase the services of our organization within the next biennium. We pledge our continued efforts to do as effective job as we can within the limits of our abilities and resources, and to work constantly to improve and strengthen those services now being provided.

Books of Interest

THE PALM-WINE DRINKARD

$2.75

By Amos Tutuola

New York: Grove Press

WHEN you were out of a job, did you ever think of changing yourself into a canoe and having your wife paddle you across a river as a ferry? You can make money that way. The hero of this bewitching tale did.

Did you ever see a Drum that beat itself? A Song that sang itself? A Dance that danced itself? You better read this amazing book if you haven't. It's packed full of wonderous things that keep you moving rapidly from page to page. You're never quite sure what you're going to meet, but what you do, be it grisly or humanely touching, is fascinating.

The HERO of this novel from Africa, an African, is a human who is a god and a juju man. In the twinkling of an eye he can turn himself into a lizard, bird, fire, a pebble that throws itself. He can become invisible Air. He can change his wife into a kitten. And he does. He has to. Never have you met a man with such a genius for getting himself into one dire, dangerous situation after another from which he has to extricate himself magically.

The "god and juju man," otherwise unnamed in the tale, was the son of the village's richest man. Our hero was the oldest of eight children, seven of whom were hard-working and industrious. He, however, was "an expert palm-wine drinkard." From the age of ten he had no other ambition but to drink palm-wine. This he did day after day, from morning until night.

His father was an understanding man. He assured his son's liquor supply. He gave him a palm-tree farm nine miles square containing 560,000 palm trees. A private tapster for the trees was supplied also.

For fifteen years all went well. The tapster tapped the trees. The drinkard drank. Life was rosy. Then catastrophe struck.

Tapster Topples

The expert tapster, while tapping atop a tree, tippled and toppled. When they picked him up at the base of a tall palm, he was dead gone. So they buried him.

But our hero couldn't find another expert tapster of like ability. He decided, therefore, to seek out his Dead Tapster in Death's Town and bring him back to resume his tapping. He had to have his liquor in proper quality and quantity even though a dead man had to be his bartender. He was "the palm-wine drinkard."

The horrendous, spine-tingling adventure of our hero on his journey from his native village to Death's Town, where all the dead reside, make up this macabre tale. It's an out-of-this-world yarn of a juju man "drinkard" who will do most anything to get his proper drink. And those of you with a sense of humor will get many a chuckle while traveling with him.

—NORBERT L. KELLY, Ph.D.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office. Raleigh, N. C., under the authority of the Act of August 24, 1912.

SEPT.-OCT., 1955

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

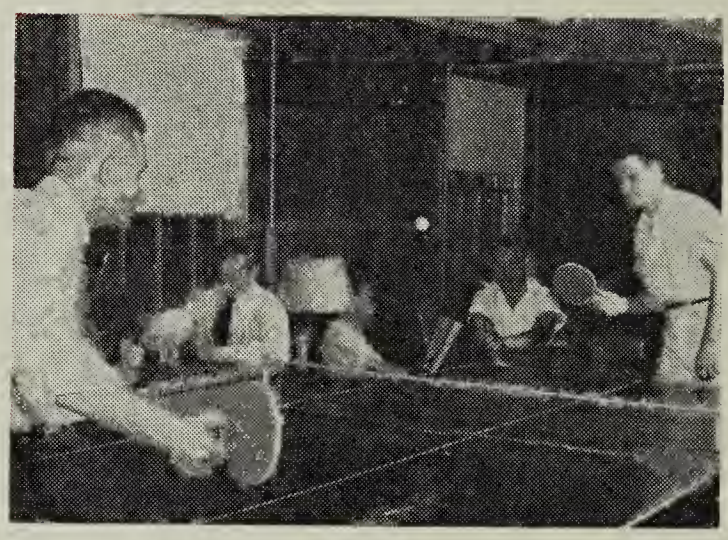
Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center has a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM
OF THE
NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS, M.D.
Clinical Director

INVENTORY

VOLUME V NUMBER 3
SEPTEMBER-OCTOBER, 1955
RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request. This journal will not be sent to persons other than those requesting it.

Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

I ran across a copy of *Inventory* in the waiting room at the Ecusta plant here in Brevard. As a minister I don't see how I can do without it. Therefore, please put me on the mailing list. I need information and help in dealing with alcoholics in and out of the church.

Ben F. Ormand, Pastor
Brevard-Davidson River
Presbyterian Church
Brevard, North Carolina

Films On Personality

We have just a few months ago organized an AA group in Elkin, N. C. As we have for our use a screen and movie projector, I am writing to you for information on how to go about getting films to show to our group. I have been a patient at Butner and have seen pictures of this type and feel sure they would help our members.

Name Withheld

All the films which are used in conjunction with group therapy at Butner are available through the Film Library of the State Board of Health. Anyone wishing to borrow these films to show to AA groups or other types of gatherings, should write the following address for further information: Roger Whitley, Chief, Visual Aids Division, State Board of Health, Raleigh, N. C.

It was a year ago this week that I was at Butner Rehabilitation Center and I am writing to thank you and all affiliated with it for the wonderful treatment and guidance I have received. This past year—12 months of complete sobriety of mind as well as body—have been wonderful.

I have enclosed a sort of "Thank you" piece that I hope you will find worthy of publishing in the *Inventory* magazine.

Edward P.
Wilmington, N. C.

To one who has spent many miserable years in the relentless grip of alcoholism, sobriety and peace of mind is a priceless possession. The Thank You piece, printed elsewhere in this issue humbly expresses Edward's happiness in recovery.

We have studied your journal *Inventory* with great interest and believe it to be one of the outstanding periodicals in its field.

Dr. Hans Meyer
Institute for Alcoholism Research
Berlin, West Germany

Serious Error

The article entitled, "The Treatment of Acute Alcoholism" in the May-June issue of *Inventory* contained a serious typographical error on page 29, which I am sure the editors will want to correct. Referring to the drug chlorpromazine, the article states, "It must be used when there is coma due to alcohol or barbiturates." If followed, this advice might result in the death of an alcoholic patient.

An Anonymous Reader

The editors regret very much that this typographical error went unnoticed. The sentence in question should have read, "It (chlorpromazine) must NEVER be used when there is coma due to alcohol or barbiturates." The sedative effect of chlorpromazine if added to the similar effects of quantities of alcohol or barbiturates could paralyze the brain centers controlling breathing and heartbeat—thus causing death.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

IT was our pleasure recently to visit North Carolina Women's Prison at the invitation of its capable new superintendent, Mrs. Elizabeth McCubbin. Naturally, we enjoyed seeing the facilities there and we noted with some satisfaction the generally high quality of the surroundings and care provided the inmates. But the primary reason for my visit was to discuss with Mrs. McCubbin the problem of alcoholism among the women prisoner population.

It seems certain that alcoholism is *one* of the problems confronting prison officials as they espouse the new concept of prisoner rehabilitation. It most certainly is not the *only* problem. There are others equally important, involving personality, environment, etc., which must be faced and solved if rehabilitation is to be successful. But according to Mrs. McCubbin, the presence of alcohol problems is evident in a sizeable proportion of women prisoners.

Meetings With Inmates

At Superintendent McCubbin's request, the NCARP is going to hold a series of educational meetings with the inmates of N. C. Women's Prison. Through these meetings an effort will be made to locate prisoners who are alcoholics and who sincerely want help in controlling their condition. We hope that our educational sessions might stimulate the formation of an active AA group within the Prison, as well as other constructive steps toward a more effective approach to this problem.

Neglected Field

The problem of alcoholism is by no means limited to women prisoners. We suspect that there are hundreds of convicted lawbreakers passing through our prisons system each year who are addicted to alcohol. We wish it were possible for this Program to launch a full-scale effort to rehabilitate those alcoholics who are in our prisons. This is a neglected but potentially rewarding field for alcoholism programs to enter. But severe limitation of funds and staff prevent our undertaking more than a token effort at this time. It is our hope that this very small beginning in work with prisoners will lead to something more adequate in the future.

Every day we see indications that individuals and groups in our society are waking up to the fact that alcoholism is a problem of major proportions calling for intelligent action. We have already touched on the awakening interest in alcoholism as it affects our prison population. The General Convention of the Episcopal Church has recently labeled alcoholism a number one problem to be faced by their denomination. The

(Continued on page 18)

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

ST. LOUIS. An estimated 5,000 members attended the 20th Anniversary AA Convention here. Thanks to our unofficial reporter, Dave C., who forwarded copies of the **AA Bulletin,** here are some of the highlights: A "Third Legacy" resolution was adopted authorizing the General Service Conference of Alcoholics Anonymous to become the guardian of the Traditions of Alcoholics Anonymous, the perpetuator of the World Services of the Society, the voice of the Group Conscience of the entire Fellowship and the sole successors to its co-founders, Dr. Bob and Bill. This Convention was the first time the 700 Family Groups throughout the world have held an international meeting. An amazingly fast-growing organization, the Al-Anon Family Groups now have their first basic-textbook, "The Al-Anon Family Groups—A Guide for the Families of Problem Drinkers," ($2, Al-Anon Family Groups, Inc., Box 1475 Grand Central Annex, New York 17, N. Y.) Al-Anon Groups believe in the importance of the Twelve Steps for themselves as well as for AA's. For them, "The AA way of life is for the whole family; only by sharing it together and with the children can the full reward of a perfect family relationship be approached." Many non-alcoholic celebrities, including President Eisenhower, sent messages of praise and congratulations. Some were present. Henry A. Mielcarek of Allis-Chalmers spoke to the assembly. He credited AA with a large measure of the success of the Allis-Chalmers program. Formerly, he said, 95% of the employees who were diagnosed as chronic alcoholics had to be discharged. Today, 70% of such cases are salvaged.

NEW YORK. The new edition of **Alcoholics Anonymous,** the new Big Book, is now off the press. Priced at $4.50 per copy, $4.00 for AA Groups, the new edition has 612 pages as against 400 pages in the old. The first 175 pages of the original work are intact. Changes include more personal stories (37-24 of them brand new and twice as long). The new edition also emphasizes desirability of accepting AA way of life **before** "low-bottom" is reached. Many of the new articles are by these "high-bottom" AA's. Order from: General Service Headquarters, P. O. Box 459, Grand Central Annex, New York 17, New York.

RALEIGH. The NCARP made tape recordings of all talks delivered during the State AA Convention at Wilmington in May. AA groups desiring to borrow one or more of these tapes should write NCARP, 15 West Jones Street, Raleigh.

Specify name of speaker: Mary McM., New York City, "My Story"; Allan G., Edtontown, New Jersey, "Progression Of Alcoholism And Progress in AA"; Dr. H. Thomas M., New Castle, Del., "The Profile Of An Alcoholic"; William A. C., New Castle, Del., "My Story"; Margaret McM., Reidsville, N. C., "My Story"; Henry "Chuck" C., Richmond, Va., "The Secret In Surrender"; Robert "Bob" T., Gulfport, Miss., "The Answer"; and Chaplain Archie D., Greensboro, N. C., "My Story."

ASHEVILLE. Several months ago some civic and professional leaders here organized the Asheville Citizens Committee on Alcoholism. They hoped to arouse more community interest and concern over the problems of alcoholism. Ackowledging their need for self-education first, the Committee held a series of learning sessions, asked ARP staff members and others to be instructors. Their own knowledge sharpened, the Citizens Committee wanted others in the community to share what they'd learned. Their next move: sponsorship of a community-wide educational institute on alcoholism, scheduled for the first two weeks in October. Nearly one hundred different civic and church groups in Asheville and Buncombe County, meeting at their regularly scheduled time, will hear speakers explain the facts about alcoholism. NCARP staff members will handle the speaking chores.

ICELAND. In 1954, the Parliament passed legislation giving the Government a complete monopoly over the importation and sale of all spiritous liquors (anything over 2¼%). One of the results of the law is the establishment of sanitoria for alcoholics. Seven hundred fifty thousand Icelandic crowns earmarked for alcoholic rehabilitation were allocated for 1955-56. Projected expenditure for alcoholism treatment during each of the years, 1957 through 1959—one and one half million crowns.

WASHINGTON. A Bill to establish a Medical Advisory Committee on Alcoholism in the Department of Health, Education, and Welfare, was introduced in the first session of the 84th Congress last February and is now in the Committee on Interstate and Foreign Commerce in the House of Representatives. The National Committee on Alcoholism and the American Medical Association together with other interested organizations are urging passage of the Bill. H R 3937 would provide a committee appointed by the President which would advise and cooperate with the U. S. Public Health Service (particularly with the Mental Hygiene Division) in promoting the education on alcoholism throughout the agencies of the Federal Government. Acting also through the State departments of health, the committee would promote education on alcoholism throughout the 48 States. The committee would advise educational bodies on medical matters connected with alcoholism and provide material for inclusion in the syllabus of various educational institutions. Combining medical, educational, community, and sociological points of view, advice would be given regarding the cure, treatment, and prevention of alcoholism throughout the country. Tar Heels interested in urging passage of the Bill can write Representative F. Ertel Carlyle, a member of the Committee on Interstate and Foreign Commerce, the House of Representatives; Washington, D. C. Chairman of this committee is Rep. Charles A. Wolverton of New Jersey.

IT'S MY OPINION

THIS DEPARTMENT IS FOR THE USE OF AA MEMBERS WHO DESIRE TO EXPRESS IN 300 WORDS OR LESS THEIR IDEAS, OPINIONS, AND PERSONAL EXPERIENCES. ARTICLES FROM AA'S UP TO 2,000 WORDS WILL BE CONSIDERED FOR PUBLICATION ELSEWHERE IN INVENTORY.

"Why should we be in such desperate haste, and in such desperate enterprises? If a man does not keep pace with his companions perhaps it is because he hears a different drummer. Let him step to the music that he hears in his heart, however measured or far away it be."

I HAVE thought about these words many times during this last year. In the twelve years or more that I worked as a front office clerk in luxury hotels in New York City and as host in winter resorts, I kept up such a desperate pace, and whatever it was that seemed to tell me what to do gave me an entirely false sense of values and a false security. I tried, not only to "keep up with the Joneses," but to keep ahead of them as well. When the big crash came for me, after the social and solitary drinking caught up with me, I found that I truly was way ahead of the Joneses, because none of them went with me to the eleven hospitals and institutions that I was in for the better part of five years.

After the last hospital and psychiatric treatment was given me—a sort of post graduate course was the final touch—offering thirty-seven electric shock treatments, I came into Alcoholics Anonymous after a rehabilitation program and rest at Butner, North Carolina, with a completely blank and searching mind—(Working on both A. C. and D. C. current).

During the past twelve months I have continually thanked God for the wonderful guidance I received from Butner and through my affiliation with AA, enabling me to find myself and other people for their true selves and true value. It is said that it is not hard to become a success in a big city, that it is harder in a small town where everyone knows you and you know everyone else. However true that may be, I have found a peace of mind and a sense of security that I never knew existed.

I am happy in my work, my AA activities, and have again found my place in my church. I am not trying to "keep up with the Joneses" any more—I left them at the AA Club door or at one of the bars in Las Vegas. I try now to keep step with just myself; I try to put first things first these days, to speak the truth, to fear God, and to remember that gentlefolk do not whine.

In closing I would like to say, as St. Paul has written: "I am glad that I was afflicted so that I might come to know the power of God."

—Edward P.
Wilmington, N. C.

IN this day and age success in life seems to revolve around the question of whether one knows the right people or not. And that holds good in AA. Who are the right people?

In business, to get anywhere, you just must know the right people.

In social life, you get along by knowing the right people.

In politics, if you want anything,

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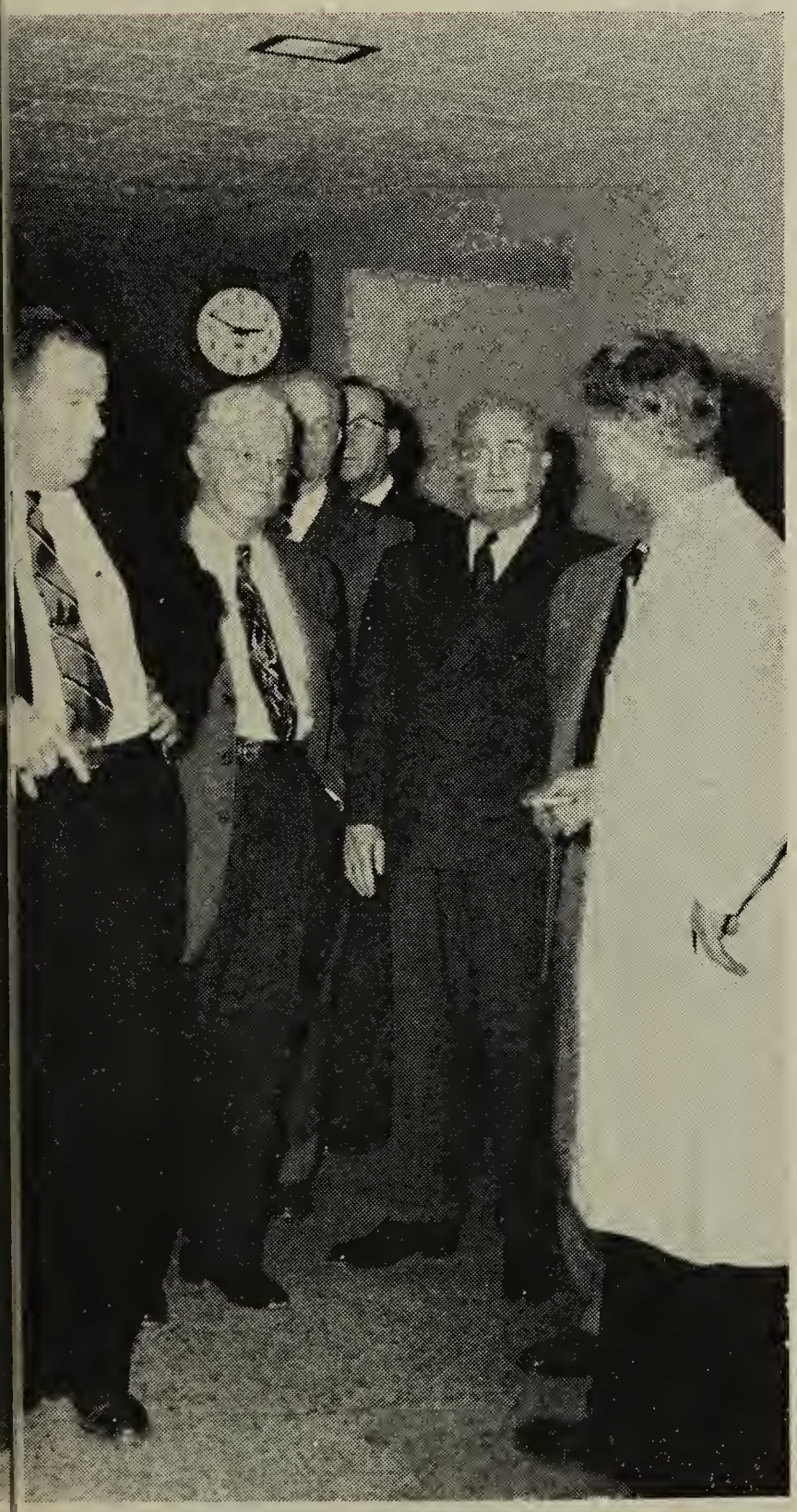
VOL. V, No. 3 **INVENTORY** SEPTEMBER-OCTOBER, 1955

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

ALCOHOLISM SERVICES AT

N. C. MEMORIAL HOSPITAL



Dr. Ham conducts Hospitals Board of Control on tour of new South Wing.

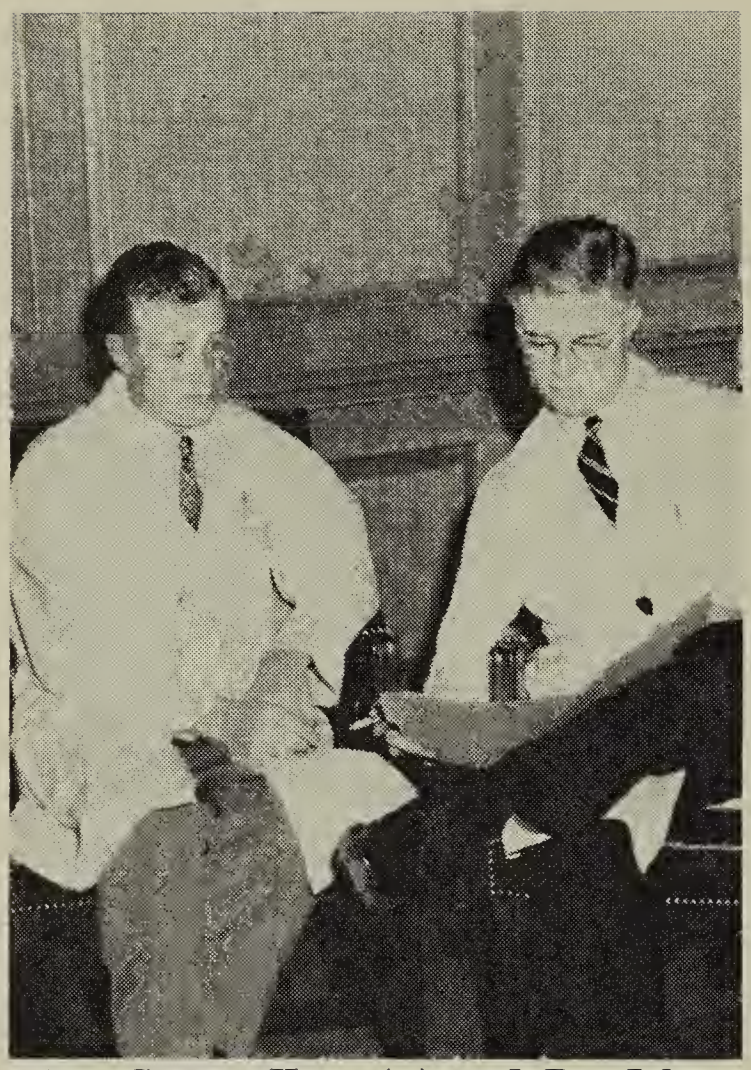
Specialized teaching and treatment are successfully blended.

BY GEORGE ADAMS

FROM all parts of the State sick persons troop to Chapel Hill's N. C. Memorial Hospital in search of health. They come with deformed limbs, kidney ailments, heart conditions, allergies, and most of the other maladies which plague mankind. Among those who receive expert care and treatment at Memorial Hospital are an increasing number of the State's alcoholics.

Last January, the University hospital at Chapel Hill opened its doors to sick alcoholics. The facility there is set up to care for alcoholic patients who sincerely wish to attempt a realistic solution of their drinking problem through psychiatric therapy. At present, admission is limited to white males and females. Facilities for Negro patients will be provided as soon as funds and staff are available to open more wards.

The action of hospital and university officials in admitting alcoholics is important for several reasons. First, it does provide more bed space and care for alcoholics. Equally im-



Dr. George Ham (r.) and Dr. John Ewing supervise treatment services.

portant, it establishes a center for alcoholism research. Perhaps its most effective service is teaching young medical students to approach the alcoholic as a legitimate patient who can be treated successfully.

Like most university hospitals, N. C. Memorial is first and foremost a *teaching* hospital. Its chief function is to provide a wide variety of clinical cases with which young medical students, interns, and residents—and to a lesser extent, social workers, nurses, psychologists, etc.—may sharpen their diagnostic and treatment skills. Physicians and others of allied professions in training at the State University now get experience in diagnosing and treating alcoholism, along with all the other illnesses known to medical science. This training and experience have been largely lacking in our medical schools up

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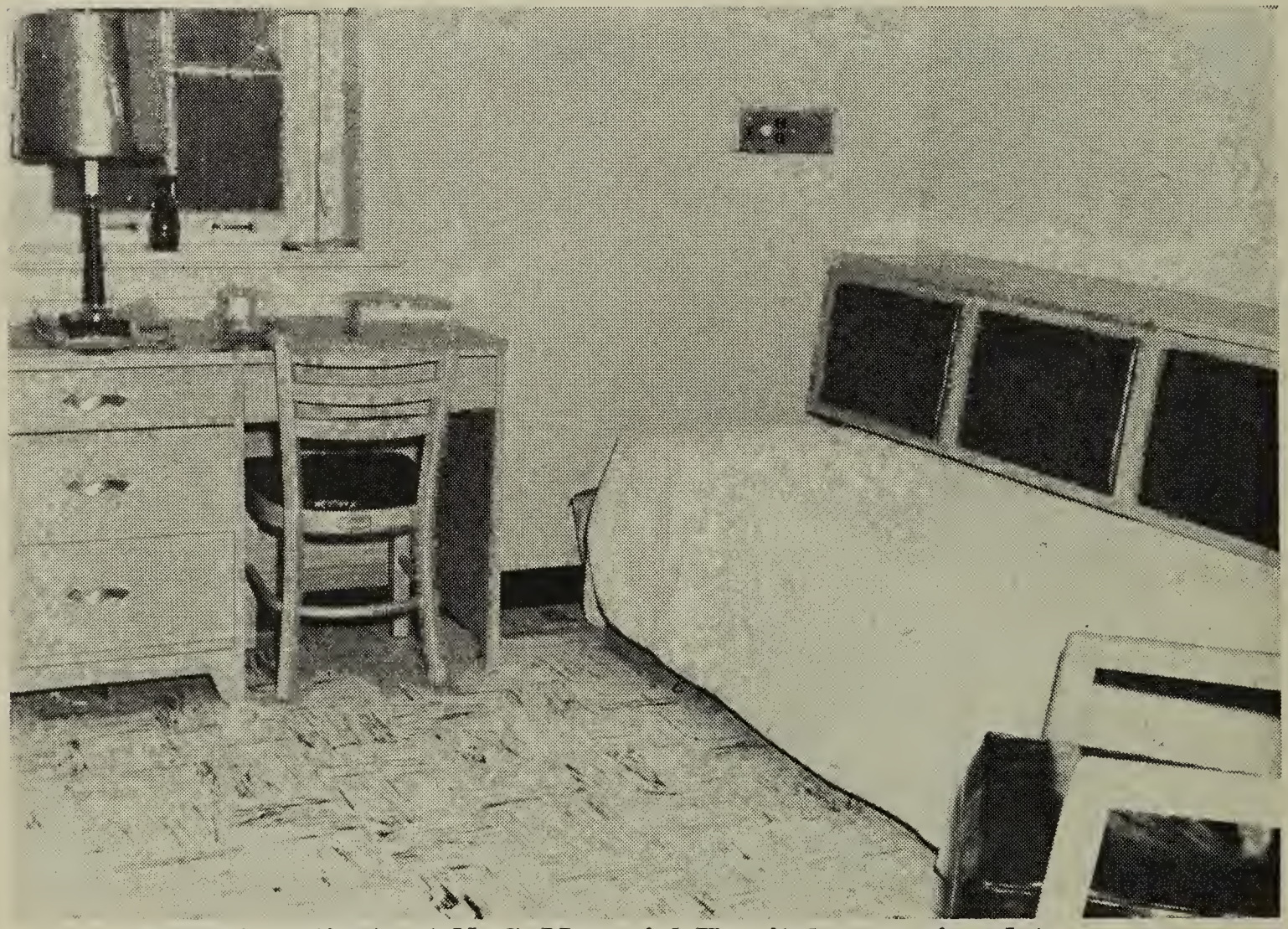


Alcoholic patients at N. C. Memorial Hospital are assigned to rooms like this. The sofa on right converts to a comfortable bed at night.

The Non-Alcoholic Therapist

The idea that only an alcoholic can understand and rehabilitate another alcoholic is false reasoning.

BY ARTHUR LERNER, Ph.D.
COUNSELOR, LOS ANGELES
CITY JAIL, LOS ANGELES, CALIF.

ONE of the most confusing problems in the alcoholic rehabilitation field centers around the idea that "only an alcoholic can rehabilitate another alcoholic." Too often, alcoholics reason thusly, "We're different! We drink! No one understands our plight unless he too drinks. Only then can this other person help us."

The above kind of reasoning is much like a malaria sufferer stating that the sole person who can help him is another malaria-ridden individual. This logic would imply that a malaria-free doctor treating the malaria patient would be of no help. Obviously, such is not the case.

Generally speaking, an alcoholic believes that another person who is himself an alcoholic may feel compassion and be far more sympathetic toward his condition as compared with a non-alcoholic. Therefore, this means, according to such a mode of thinking, that there is understanding present. There is no denying that much good may come from situations where alcoholics are endeavoring to understand each other. AA is only one example of living testimony to such.

It should be kept in mind, however, that there are many psychological determinants why people are drawn to fellow-sufferers. Such attraction may imply a degree of understanding, but does not necessarily mean that help will automatically follow and the individual will become rehabilitated without any effort on his part. Again, AA has emphasized that the mere act of accepting and joining its program does not relieve the individual alcoholic from putting forth effort to help himself.

Understanding Not Enough

It should be re-emphasized at this point that the importance of understanding the alcoholic in order to help him to help himself can never be minimized. However, understanding, in and of itself, is not a guarantor that rehabilitation will follow. Too often has the alcoholic employed the "understanding line" as a means

(Continued on page 22)

FLORIDA'S Alcoholic Rehabilitation Program

The Florida Program promises to become one of the country's outstanding programs on rehabilitation.

BY BARTON JOHNS

IN May of this year at a mental health meeting held in the West Coast city of Fort Pierce, fifty people came to hear a twenty-minute talk about Florida's new program for alcoholics. They came to hear a twenty-minute talk and they stayed an hour and a half. Why? They had questions to ask about alcohol and alcoholism, and they wanted to know specific details about the new State program. "Why are you trying to help the alcoholic?" "Are doctors sympathetic toward the alcoholic?" "Are you working with the schools?" "Where does your money come from?" These and other equally direct questions are typical of the queries made to staff members of the newly created Florida Alcoholic Rehabilitation Program.

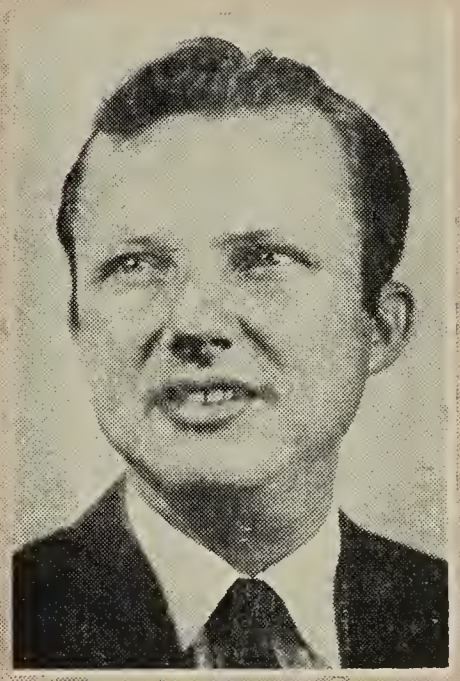
From the passing of the law creating the alcoholic program in 1953 to the present time, there has been an immediate and continuing interest in the new agency's activities. Created by the state legislature as a specialized health agency to work for the control and prevention of alcoholism in Florida, the Program is headed by Ernest A. Shepherd as Administrator. He came to Florida from New Hampshire, where he was the director of the Department of Health's Division on Alcoholism. Active in the field of state-controlled programs on alcoholism, Shepherd is the immediate past president of the National States Conference and has been a frequent lecturer at the Yale Summer School of Alcohol Studies.

Organization

The Florida Program is directly responsible to the Board of Commissioners of State Institutions, which in turn has appointed three of its members as a committee to work with an Advisory Council appointed by the Governor. Shepherd is assisted in his work of developing the Program by a clinical director, a

ERNEST SHEPHERD
ADMINISTRATOR

DOROTHY JOHNSON
PSW SUPERVISOR



BARTON JOHNS
ED. DIRECTOR

psychiatric social work supervisor, an educational director, a business manager, and clerical personnel.

When asked why the State is offering to help the alcoholic, the answer would be that the approach by the State of Florida is based on the belief that as a type of addiction, alcoholism is diagnosable and treatable. Furthermore, because of its marked social effects, the governmental approach accepts alcoholism as a public responsibility for the present.

Specialized Approach

In dealing with a condition which is estimated to be the chief health problem of 93,000 Florida citizens, the Program proposes a specialized approach which combines treatment, rehabilitation, education, and research.

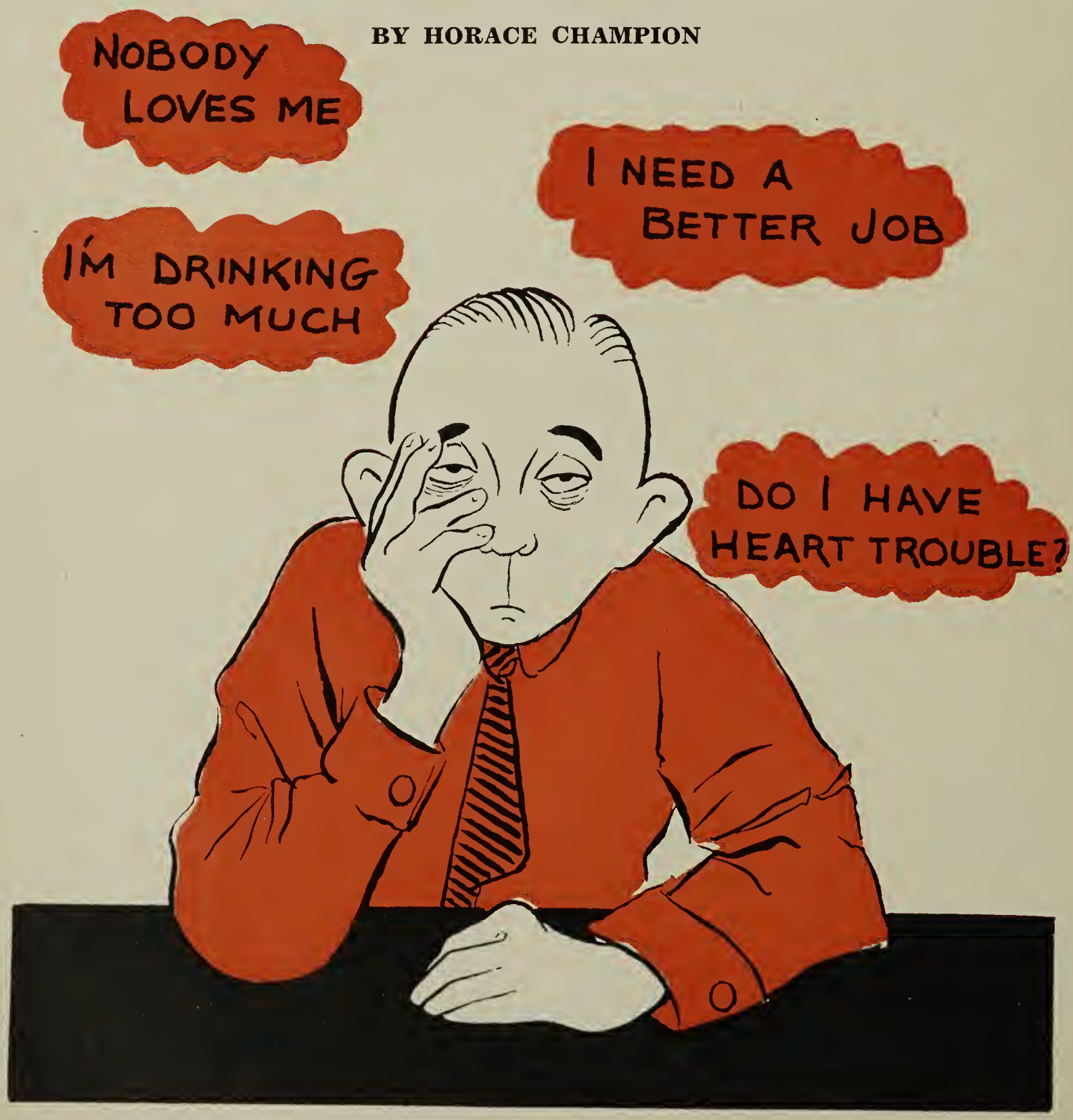
Treatment and rehabilitation services of the Program will be of two types: services providing outpatient care through regional clinics in population centers of the state, and inpatient care at a Rehabilitation Center. Alcoholism is viewed as a medical condition which requires long treatment, sometimes for a period of years. Treatment is not a quick course of injections, pills, or talks terminating on discharge from the clinic or the Center. Treatment continues through follow-up designed to assist a person to meet his changing needs. In alcoholism, as in other chronic conditions, goals for treatment and rehabilitation will vary according to the patient's condition and possibilities of recovery. The minimal aim in all cases will be to assist a person to establish and maintain sobriety; the maximum aim is to bring about desired changes within the patient through the use of all tested means and to assist him to regain his sobriety, self-confidence, sincerity, and initiative.

(Continued on page 23)

HAVE YOU THE ENERGY TO SOLVE YOUR PROBLEMS?

Understanding the problem and knowing how to solve it is not enough. One must know how to develop the right kind of energy for solving problems. Here are ways to improve your problem-solving ability.

BY HORACE CHAMPION



TO be able to face one's problems objectively and then *do something about them* is a trait all of us can improve upon by conscious and directed effort. If the alcoholic—or any emotionally immature person—wants to be relieved of his particular "symptom" one of the goals he must constantly work toward is an improved working ability to solve his problems. He may be able to recognize the problem and know what he has to do in order to solve it, but unless he has the mental and physical energy to carry the job through to completion his intelligence is of little value to him. Personal and social problems arise not so much from lack of "knowing" as from an unwillingness or inability to do what is best under the circumstances.

Many patients leave alcoholic treatment centers knowing what they must do in order to live sober, satisfying lives, yet they haven't the energy to stay sober. Getting drunk is easy; staying sober requires effort, work, energy.

The Energy Problem

The alcoholic's energies can be developed. They can be directed. They can be channeled into personally satisfying and socially constructive outlets. They can help him to overcome his problems to an unbelievable extent—but only if he is willing to accept the fact that he has unsolved problems, is willing to grit his teeth and bear for a time the emotional discomfort that is certain to arise as he stands up to his problems, and is willing to try to take over the management of his energies.

The big problem is to develop the right kind of energy, reduce the wrong kind, and mobilize and direct energy into personally satisfying, socially constructive outlets.

Daydreaming about what we would like to be, what we would like to have, is a universally used but inadequate substitute for problem solving. Daydreaming can help to set goals, but since it is the least active form of energy expression, it does not move the person one inch toward those goals. The energy must come from elsewhere.

Physical Energy Not Enough

Physical energy as a means for solving problems is not as important in this complex civilization as it was when man's needs were simple and uncomplicated. We wish for things we can't obtain by physical effort alone. Physical energy is a more active form of energy expression than daydreaming. We must have it, and use it as one of the means for reaching our goals. But physical effort is not enough.

Solving problems in this day and age demands mental effort, which is not so much a matter of native intelligence as it is of establishing a technique for thinking a problem through to the end. Recovered alcoholics often make the statement that in their drinking days they were unable to "think straight." Without "thinking" they headed for the bottled anesthetic whenever things went wrong and sometimes when everything was going along just fine simply because they knew, from experience, that a new problem would arise soon, maybe today, or tomorrow. "So let's take a drink and forget about it."

Developing Mental Energy

One does not gain experience for solving problems by running away from them. One does not gain the mental energy necessary to overcome problems without exercising his mental energy by trying to solve his problems. Mental energy, like water, seeks its own level. It deve-

(Continued on page 26)

Two barriers to adequate treatment of the chronic alcoholic are the unwillingness of the physician to accept him as a bona fide patient and the woeful unpreparedness of the physician to treat him.

A PHYSICIAN LOOKS AT

ALCOHOLISM is a disease of three facets. There is physical disease, mental or emotional aberration (some prefer to designate it as personality defect or disorder), and most important of all, there is spiritual conflict or need. All three elements of major distress must be recognized, appreciated and understood by the physician if any progress is to be made in search for solution.

The American Medical Association has acknowledged alcoholism as a treatable illness, and some medical practitioners of our day are beginning to accept it as such. Through the admirable achievements of Alcoholics Anonymous we have seen that alcoholics can and do achieve sobriety. And rarely, apparently through our own individual effort, influence is carried to the patient which helps him to regain some essence of control over his drinking. We see, too, the results of spiritual approach through personal evangelism that can often have far-reaching effect. These and other signs of our times place an added responsibility upon physicians that they undertake without hesitation the care of those alcoholics who come to them for medical help.

There seem to be two significant barriers to adequate treatment of the acute or the chronic alcoholic. The greater barrier is the unwillingness of the practitioner, or the internist, or the psychiatrist to accept such a patient freely, genuinely; and to provide service commensurate with present medical facilities. The other significant barrier, almost of equal importance, is the woeful unpreparedness of the physician to treat that patient.

Ambivalent Attitudes

This is not to say that the average physician does not have an adequate knowledge of the *means* of therapy. His unpreparedness to deal with an alcoholic patient lies in his own ambivalent attitude towards that patient. Most of us still nurture the feeling that the alcoholic is a moral delinquent rather than a sick man. Most of us from childhood were taught that the behavior problem of the "town's drunk" arose from faulty

Dr. Thomas T. Jones was one of the first physicians in the State to accept alcoholics as bona fide patients and to show them the understanding they needed. A very busy man with a large practice and heavy speaking schedule he still finds time to encourage other doctors to accept alcoholics as patients and to serve as chairman of the Alcoholism Sub-Committee of the N. C. Medical Society.

ALCOHOLISM

BY THOMAS T. JONES, M.D.

DURHAM, N. C.

inheritance, ingrown cussedness or shameful lack of personal integrity. And we find today it is easier to pass the buck, to refuse treatment outright, rather than acknowledge our own inadequacy or imperfection which stands in our way when it comes to making the effort to comply with the alcoholic's need.

Objective Response

All the alcoholic asks is that he be treated as a human being without criticism, and without judgment. We as physicians have the means to initiate and to further adequate treatment on a high and gratifying plane, if we could but become objective and selfless in our response. Our greatest qualification to serve under such circumstances, is the acceptance of the fact that the alcoholic is a bona fide patient and merits the best that we have to offer.

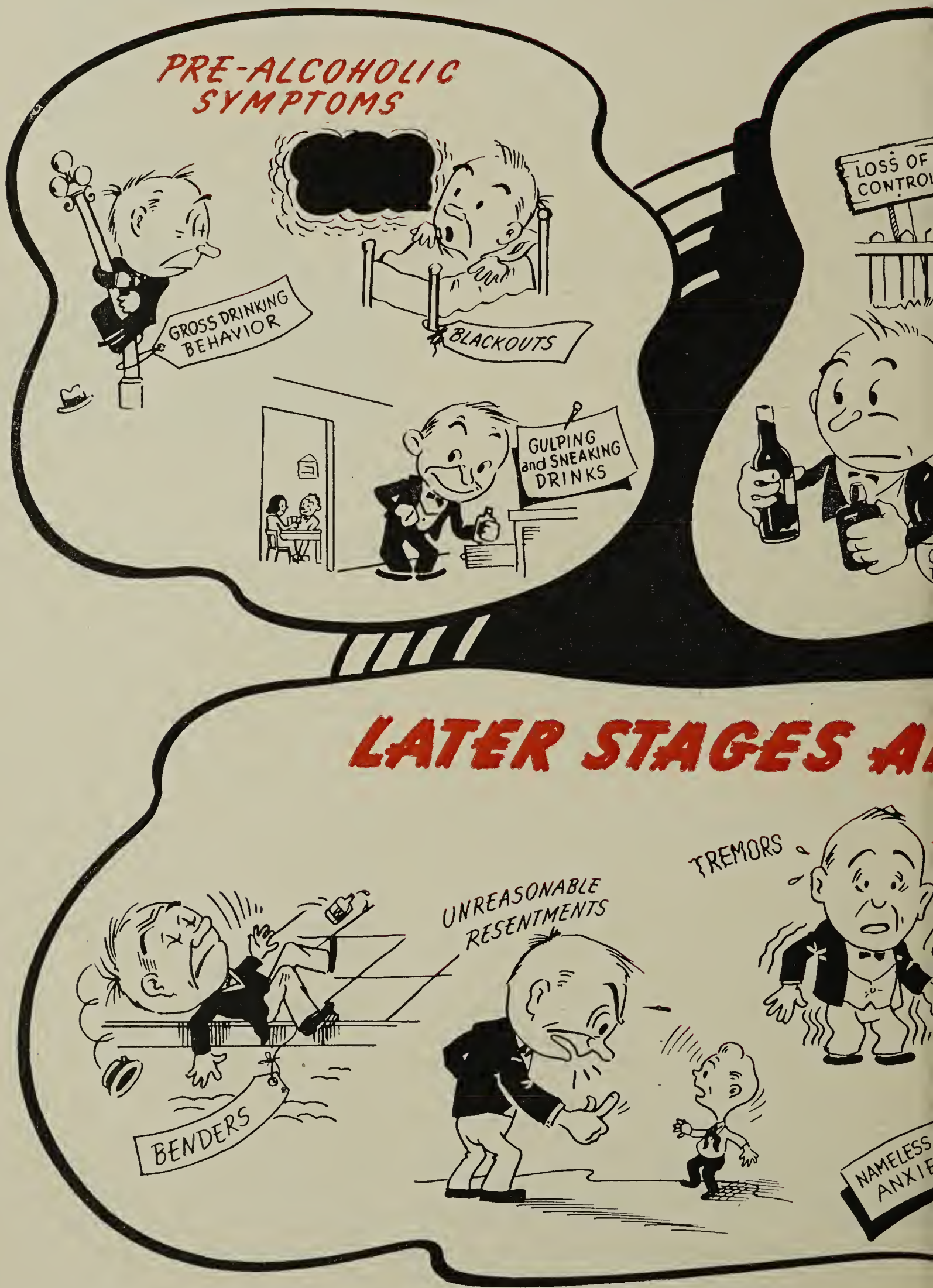
Such publications as the *Grapevine* (national AA magazine), the splendid state-published *Inventory,* and books like *Twelve Steps, Alcoholics Anonymous, A Sober Faith,* and a host of others can contribute much to our understanding of the alcoholic. They can serve also the growth of our own professional integrity, and bring rewards of a more adequate and satisfying response to this major need that has so long harassed the church, the state, and our profession.

It is the writer's feeling that the alcoholic must be treated first of all with the heart—and only in minor degree with the head and its know-how. The patient will remember the attitude of his doctor far longer than his prescription. And although the alcoholic may have impaired sensibilities, his sensitivity is made keener by his suffering. This can easily be measured by the chip he so often carries on his shoulder. He feels hostility towards a professional world that has so long and so patiently denied its responsibility by inaction, while giving lip-service to an abstraction that the alcoholic is a sick man.

The problem of today, then, is more the conversion of the physicians to their responsibility for treatment, than for need of more

(Continued on page 31)

PROGRESSIVE SYMPTOM



Drawing courtesy Hazelden Foundation, Center City, Minnesota

OF ALCOHOLISM

Progressive symptoms courtesy Yale Center of Alcohol Studies

Program Pointers

(Continued from page 3)

Methodist Church, too, has officially acknowledged the illness as one of the pressing problems of the day.

I have cited these as only three instances of what is rapidly becoming a great surge of public concern over alcoholic illness. This trend is encouraging to those of us who have always contended that public education is the cornerstone of any effective program of rehabilitation and prevention of alcoholism. We are now beginning to see some of the rewards of our labors. Paradoxically, though, now that the grass roots are stirring with interest, the NCARP is more limited than at any other time in its financial recources for meeting the increased demands for educational services.

Two Public Institutes

Requests for ARP literature are coming in at a steady clip, and our printing budget is being strained beyond its capacities. Each day's mail brings requests for ARP speakers to appear before a great variety of group meetings throughout the State. We regularly receive calls from civic clubs and other organizations for assistance in staging community educational institutes on alcoholism. Two institutes of this type will be held during the next two months—one in Asheville and the other in the Hickory-Newton-Conover area. ARP speakers will fill nearly one hundred speaking engagements in the Asheville-Buncombe County area during the two-week institute there. In addition to these services, we are often called on to assist communities in organizing their own local programs on alcoholism.

We are certain that these and other educational services of the ARP are already bearing fruit in a changing public attitude toward alcoholism and its sufferers. But the job requires time and money and adequate personnel—considerably more of all three than the ARP has at present. Perhaps our greatest need is for more adequate funds. Given the funds, we can get the personnel and provide them with the educational literature and other materials they would require to satisfy the needs of our citizens.

The people of North Carolina obviously want the educational services of the NCARP. We hope that they will support us in our efforts to secure more adequate funds with which to do the kind of job that is being asked of us.

It's My Opinion

(Continued from page 6)

you must know the right guy, or the right people.

And so it is right down the line. It's always a matter of knowing the right guy or the right people, at least that is the way it seems.

But in AA! I know—I got my AA by knowing and associating only with the right guys and gals. All *had* to be right people. So it all adds up to one question: Who in AA are the right people? The answer is simple. In business, society, politics and the like, the right people are measured by the standards of wealth, influence and power, although in most cases these have been earned, and, I might add, the end result is not always satisfactory. The success thus achieved has not always proved a genuine

blessing. But not so in AA.

The right guy, the right gal, the right people are those without regard to race, color, power, influence or material wealth, who have accepted and who practice the 12 Steps, and who continue to do so without interruption, and who know they don't want to take that first drink and are ready and willing to tell you how they do it. They and they alone are the right people in AA. Seek them out. They are not hard to find; latch on to them and you will find out you too are a right guy or gal.

—Jerry H., New York, N. Y.

N. C. Memorial Hospital

(Continued from page 8)

until recently. Its inclusion into the training program at UNC is a hopeful sign for the future.

The North Carolina Alcoholic Rehabilitation Program has a special interest in the developments at Memorial Hospital. This interest dates back to 1951 when state officials first decided to allocate funds to build a separate psychiatric wing onto the hospital. The Hospitals Board of Control agreed at that time to transfer some of its available funds, including $150,000 from the NCARP, in order that work on the psychiatric wing could proceed without delay. University officials, in turn, promised to include facilities for the treatment of alcoholics within the new psychiatric wing.

As construction neared completion, Dr. George Ham started looking for a psychiatrist qualified to head the services for alcoholics. He found the man he wanted at the NCARP Treatment Center. He is Dr. John A. Ewing, then staff psychiatrist at the Treatment Center and senior physician at the Butner State Hospital. Dr. Ham offered Ewing the job as Coordinator of Alcoholism Treatment Services at Memorial Hospital plus an instructorship in psychiatry. Ewing, happy at the opportunity to combine his two chief professional interests, accepted the new job and joined the staff of N. C. Memorial in September, 1954.

Rules For Admission

The first task Dr. Ham handed Ewing was to decide just how the admission and treatment of alcoholics would be handled in the hospital. After a period of study and conferences, Ewing submitted his recommendations. His proposals were accepted by Dr. Ham and hospital officials and were approved by John Ruggles and his ARP Committee of the Hospitals Board of Control. During the past several months, experience has forced modification of some of Ewing's original proposals, but by and large the rules for admis-

THE PRISON HOME

WHERE parents, by conscious or unconscious antagonism to him, reject a child—that is, hold him off and force him into emotional seclusion by their own indifference and disapproval—they prevent the growth in him of those positive relations to people and things that are essential to confident and happy life. The home of such a child is not called a prison; nor are his parents thought of as prison guards who forcibly lock their hapless victim within the cell of his anxious, resentful, isolated ego. But such a home, psychologically viewed, is as much a prison as though it had visible bars.

—H. A. Overstreet in *The Great Enterprise*

sion of alcoholics are now clear cut and firmly established.

Following closely Dr. Ewing's original recommendations, here are the present rules for admission and treatment of alcoholics at N. C. Memorial.

First, the alcoholic must apply for admission in advance and, preferably, on referral from his local physician. Application should be made to the Resident in Charge of Admissions, c/o Department of Psychiatry, N. C. Memorial Hospital, Chapel Hill, N. C.

Period Of Treatment

Alcoholic patients are expected to sign voluntarily for a minimum stay of 10 days, unless hospital physicians agree to a shorter period. For example, a patient who planned to transfer to the Alcoholic Rehabilitation Center at Butner could be permitted to do so as soon as he had improved enough physically under treatment at Memorial Hospital. Except in these and similar special cases, all other patients will be expected to remain for the minimum 10-day period.

The prospective patient should be prepared to pay full charges for the 10-day treatment in advance. Fees for alcoholics are not one cent more than the standard per diem rate charged any other patient entering the hospital.

The purpose of setting up a minimum period of treatment in South Wing is clear. Only in this way can time be allowed to treat the patient's physical condition, study his case history, investigate the personality factors involved in his drinking, and begin initial psychotherapy.

Patients suffering the physical effects of intoxication will not as a rule be refused admission, provided they meet the requirements for entrance. But the Department of Psychiatry wants it clearly understood that they are not operating primarily a "sobering up station," where repeaters may come any time to get over recurrent benders. Alcoholics who have no intention of trying to solve their problems in a realistic way are urged to do their sobering up elsewhere. As Dr. Ewing puts it, "We have two objects in operating our alcoholism service. One is to teach our students the total care of the acutely ill alcoholic, including the physical management. More important, we intend for them to learn the proper psychological approach to alcoholism, in order to help the alcoholic regard his drinking as a symptom of his psychological disorder which requires therapy."

While some patients may remain in the hospital longer than 10 days, it is expected that most long term psychotherapy will take place in the out-patient clinic. Under this arrangement patients may leave the hospital, return to their homes and jobs and

ALCOHOL THE PEACEMAKER

IN the tragic conflict between what he has been taught to desire and what he is allowed to get, man has found in alcohol, as he has found in certain other drugs, a sinister but effective peacemaker, or means of securing for however short a time some way out of the prison house of reality.

—from "Alcoholism in Missouri" a statement by the Missouri State Medical Association's Committee on Alcoholism.

still continue their treatment through regular appointments in the clinic. Group therapy sessions for alcoholics, under Dr. Ewing's direction, have been in progress now for several months in the out-patient clinic. A patient doesn't have to be a "graduate" of Memorial's South Wing in order to be eligible for treatment in the clinic. Already, Dr. Ewing is receiving referrals of patients discharged from the NCARP Treatment Center. Other clinic patients are self-referred.

In-patient and out-patient services are vital to an effective alcoholism program. But they are not enough, say Dr. Ham and his staff of psychiatrists. They feel that the real test of the effectiveness of clinical facilities is the presence of a well organized research program. Particularly is this true, they say, in a teaching hospital. There is so much yet to be learned about alcoholism and its sufferers that ripe fields for inquiry lie at every hand. Research at N. C. Memorial will explore some of these. Proposed areas of investigation include: a study of the newer drugs and their use in treating the acutely ill alcoholic, group psychotherapy and the group dynamics involved; a study of the role of family members in the alcoholic's illness. In connection with the latter study, group therapy for spouses and parents of alcoholics is planned.

All the services for alcoholics are housed in the attractive, well-equipped South Wing of the hospital. On the lower two floors are located the consultation rooms, waiting rooms, and doctors offices for the out-patient clinic. There is space, too, for a research laboratory. The upper four floors, only two of which are currently in use, are given over to in-patient facilities. As soon as nursing and other personnel are available, an additional floor will be opened. With the additional space, the staff believes it will be possible to set up completely separate accommodations for alcoholics if necessary.

N. C. Memorial Hospital, its up-to-date plant and its dedicated staff of physicians, is something to which North Carolinians can point with pride. Its South Wing, too, has the potential for developing one of the nation's leading alcoholism centers.

THE MAN IN THE GLASS

When you get what you want in your
struggles for self
And the world makes you king for a
day,
Just go to a mirror and look at yourself
And see what that man has to say.

For it isn't your father or mother or wife
Whose judgment you must pass;
The fellow whose verdict counts most in
your life
Is the one staring back from the glass.

Some people may think you a straight-
shootin' chum
And call you a wonderful guy,
But the man in the glass says you're
only a bum
If you can't look him straight in the
eye.

He's the fellow to please, never mind all
the rest,
For he's with you clear up to the end.
And you've passed your most dangerous,
difficult task
If the man in the glass is your friend.

You may fool the whole world down the
pathway of life
And get pats on the back as you pass,
But your final reward will be heartaches
and tears
If you've cheated the man in the glass.

—Author unknown

The Non-Alcoholic Therapist

(Continued from page 9)

of rationalizing his own situation and his unwillingness to face reality.

Along with understanding, skill is a vital part of the helping process. Skill may imply many things to many people. Basically, however, skill suggests understanding put into actual operation in a refined manner. In other words, skill is the practice of acceptance with "know-how." This also means that those endeavoring to help the alcoholic to help himself should be aware of their own limitations and biases whenever these may enter the helping experience.

It is advisable to point up that skill is not a phenomenon which comes of its own accord. Training, observation, patience, knowledge, understanding and acceptance generally take a long time in ripening.

Skill in dealing with the alcoholic and his problems can be developed by those interested at the level of their own frame of reference. For example, the wife of the alcoholic can learn about her own needs and drives in order to relate to her spouse in a more adequate manner. The employer of the alcoholic, realizing it is more profitable to hire and keep instead of constantly fire, may begin to see his employee in a new light. He may exercise support by encouraging attendance at AA meetings, or discuss possibilities of medical and/or psychological help with his alcoholic employee. It is amazing how much positive influence employers may have with their alcoholic workers. Friends can also develop the skill of suggesting and listening without reproaching.

Of course, the skill and help which may be offered by the layman differs from that of the social worker, medical man, psychiatrist, psychologist and other trained professional persons. However, the point emphasized herein is that individuals interested in helping alcoholics to help themselves can do much about becoming skillful in the helping process. An example of what this means can be obtained from the remark recently made by an alcoholic to his friend. "I have finally learned that it is not too important who is helping me—alcoholic or non-alcoholic. The important thing is I am being helped and understood by people who are interested in my welfare and seem to know what to say and what to do." Such expressions not only reveal a new kind of insight but generally lead to more positive motivation on the part of the alcoholic.

THESE TICKLED US . . .

After a night of revelry the guy was having a hard time getting his key into the lock. After a little of this a man put his head out of a window overhead.

"Go away!" he called. "You're trying to get into the wrong house, you fool."

"You're the fool," retorted the drinker. "You're looking out the wrong window."

Hear no evil, see no evil, speak no evil, and you'll never be a success at a cocktail party.

A man at a cocktail party after his first drink went around shaking hands with everybody present and solemnly bade them goodbye. "Good heavens, you're not going yet, are you?" asked his host. "You've just come."

"No, I'm not going," said the guest, "but I thought I'd say goodbye to the people while I still know who they are."

"Is that you, dear?" called the wife, as her husband tiptoed up the stairs.

"It had better be me," he answered grimly.

The Florida Program

(Continued from page 11)

Outpatient clinics have been opened in Jacksonville, Pensacola, and Tallahassee; and are planned for Avon Park, Miami, Orlando, and Tampa. Clinics offer the following services: admissions and diagnosis of ambulatory alcoholic patients, such medical care as can be given in an outpatient clinic, psychiatric evaluation, psychotherapy, psychiatric social service, referral, information, and some public relations. Clinics are staffed on a part-time basis by a psychiatrist and internist; and on a full-time basis by a psychiatric social worker (or workers), and secretarial help.

The law also authorized the establishment of a fifty-bed Rehabilitation Center in the south-central city of Avon Park. Ten of the fifty beds will be for acute cases. Now in construction on a 140-acre tract of land donated by the city of Avon Park, the Center will be located in a pine woods area between two lakes. The multi-unit structure will also house the Program's state offices.

Types Of Care

Types of care which will be offered by the Center on a voluntary request basis for male and female residents of the state are: limited medical care, individual therapy, group therapy, residential living, orientation to the program of Alcoholics Anonymous, religious guidance, occupational therapy, vocational guidance, recreation, and psychiatric case work. Patients at the clinics and the Center will be charged according to a standardized system of fees; however, no patient will be denied treatment because of an inability to pay.

The Avon Park Center is planned as a "therapeutic community" which will bring together all effective methods of care and therapy and then add another element which is only beginning to receive attention—the Center's staff as it forms and maintains a healthy group life which is a curative influence.

The dissemination of information, the promotion of educational activities, and the maintenance of good public relations are regarded as an integral part of the Florida Program. An Educational Director has been appointed to carry out the following objectives: (1) inform the general public about the nature and causes of alcoholism and the methods of treatment; (2) to offer information and assistance to the professional public in their approach to the problems of alcoholism and in particular,

. . . BUT NOT TO DEATH

Work, said Oscar Wilde, is the curse of the drinking classes.

The three old friends, who'd been strangers two hours earlier, had exhausted their supply of lies, stories and songs. It was almost time for the bar to close. "Wait," said one of the group, brightly, "I just thought of a great game we three can play. Lesh one of us leave the room, and then the other two hafta guess which one of us left!"

Many alcoholics are highly skilled in the art of deception. To illustrate the extent to which they will practice it, the story is told of the drunk who was convinced he was about to die. So he staggered into the parsonage, fell on his knees before the preacher, and tearfully asked him to pray for his soul.

The preacher consented. He looked toward Heaven and said, "Lord, have pity on this poor, drunk soul."

The drunk tugged at the preacher's trousers and cried, "'Preacher don't tell Him I'm drunk. Tell Him I'm sick."

the treatment and management of alcoholism; and (3) to help alcoholics and their families recognize the illness in earlier stages and encourage them to seek treatment.

In response to the question, "Does the Program work with schools?" the answer is that although the specific responsibility of alcohol education in the schools belongs to the State Board of Education, the Rehabilitation Program is interested in providing resource materials and information sources to the schools. To that end, five of the fifteen persons who have been awarded scholarships by the Program to the 1955 Yale Summer School of Alcohol Studies are from the field of education—a university dean, a county supervisor of instruction, two principals, and a high school teacher. The group also includes three psychiatrists, a county health officer, a nurse, a social worker, a police captain, a minister, a personnel manager, and a member of Alcoholics Anonymous.

In April, one-day seminars on alcoholism for all the clergy were held in six cities about the state on an interdenominational basis. Dr. Selden D. Bacon, Director, Yale Center of Alcohol Studies; and Raymond G. McCarthy, Director of Alcoholism Research, New York State Mental Health Commission, were brought to Florida as seminar lecturers. A combined total of over 200 ministers attended the meetings. This activity is planned on a yearly basis.

The Program has an educational exhibit suitable for large gatherings or small meetings. This display has been sent to conventions, fairs, medical forums, and has been displayed on television. The sixth issue of the REPORTER, a newsletter about Program activities and interests, was published in June. The PROFESSIONAL, an alcoholism treatment digest, is published five times a year for selected mailing to professional groups such as the physician, the social worker, the clergyman, and the judge. The REPORTER and the PROFESSIONAL are free upon request to the Program.

Publications List

A recommended publications list for free and cost literature has been completed. It will be revised twice a year to reflect the current availability of literature on alcohol and alcoholism. This list also shows films on alcoholism which have been housed by the Program at the State Board of Health and the General Extension Division, University of Florida. A Speakers Bureau has been formed and staff members are available for talks to church, civic, and professional groups. Since the opening of the Bureau in March, 1954, over

CULTIVATING INSIGHT

THE psychiatrist exercises no magic in his treatment of emotional problems. He works hard, using all his skills, not to effect a miraculous change of personality in his patients, but rather to help them achieve sufficient self-understanding so they will adjust better to their emotional limitations, learn better how to utilize their capacities, and through that fuller utilization arrive at an enriched self-expression that will leave them at peace with themselves and society. His chief means of bringing patients to that desired goal is through the cultivation of their insight.

—Phillip Polatin, M.D. and Ellen C. Philtine in "The Well-Adjusted Personality"

seventy organizations have been provided with speakers.

Plans are now underway for Dr. E. M. Jellinek's paper on "Alcohol, Cats and People," which has undergone art and format changes, to be reprinted by the Program. Ernest Shepherd's pamphlet, "Alcoholism, A Family Guide to Understanding the Illness and What To Do About It," is also to be reprinted with new artwork and color.

While it is not expected that any extensive research or study will be conducted by the Program, the continued investigation of the problems of alcoholism is regarded as an obligation. From time to time, the Program will arrange through grants for projects to be conducted by recognized institutions and academic or research agencies. Other study activities will be planned and conducted by the Program staff.

Where does the money for the Program originate? The Program's income is derived from two sources: twenty per cent of an additional tax which was imposed several years ago on alcoholic beverages and the patients' fees. The estimated annual income from the beverage tax will be $281,996 for future years. $746,615 was allocated for the fiscal year, 1954-1955, for operating and capital expenses which included the construction of the Rehabilitation Center and its furnishing and equipment.

In October, the Program will host the sixth annual meeting of the National States' Conference on Alcoholism. The meeting will be at the Bal Harbour Hotel in Miami Beach. In early 1956, the Program hopes to have the formal opening of the Avon Park Rehabilitation Center with ceremonies which will include the governor and open house hours. Prior to the opening of the hospital, the Program has an arrangement with the North Carolina Alcoholic Rehabilitation Program to send a limited number of Florida patients to the Rehabilitation Center at Butner.

Changes In Attitudes

In all these various ways—control and prevention, treatment and rehabilitation, education and research—the Program is endeavoring to bring about changes in attitudes toward alcoholism insofar as they can be brought about by the use of sound information. However, the passage of a law and the works of an agency, no matter how carefully planned or administered, or how well financed, cannot succeed by themselves. In all its initial activities, the Florida Alcoholic Rehabilitation Program has benefited and will continue to welcome cooperative relationships with state and private agencies, with church and civic groups, and with the individual citizens.

THE BUSINESS OF FORGETTING

ALCOHOLICS live in a distorted world in which their self-made troubles snowball. Only through liquor can they find that hazy golden state in which they are carefree and brilliant and witty, full of grand schemes, brother to all the world. When they come out of it they realize that they have betrayed the ones who love them most. They have evaded obligations and broken promises. They are continually in the wrong and it is a terrible humiliation to be always pleading for forgiveness. With a bottle, even one drink, they can forget all these oppressive thoughts. So the period between bouts becomes shorter and shorter.

Arnold A. Hutschnecker, M. D. in *Love and Hate in Human Nature.*

Energy To Solve Problems

(Continued from page 13)

lops with practice just as physical energy develops with exercise. In their excellent book, "Managing Your Mind," S. H. Kraines and E. S. Thetford point out, "The more problems you have reasoned through and the more solutions you have implemented with action the more mental energy and the more energy of initiative you have."

Thinking before acting and acting after thinking is a generalization, but it is a start toward developing the right problem-solving technique and the mental energy it generates.

Steps To Problem-Solving

There are several steps in the problem-solving technique. They include, in this order: defining the problem, considering the facts, deciding on the best possible solution, and taking whatever action seems necessary to arrive at the solution previously decided upon.

There is nothing simple about any of these steps except perhaps for those rare individuals whose minds are so experienced at solving problems successfully that nothing seems to stand in the way of their personal, social, and economic success.

Most of us must labor through the steps deliberately and often painfully until our minds become trained to tackle problems in the right way and as they arise.

Worrying about things in general, about things that *may* happen often prevents a clear-cut definition of the problem. We haven't been feeling well lately. Should we see a doctor? When? Suppose he tells us we've got heart trouble? Will we have to stop work? How will we live? We confuse the problem with side issues and fears until we "just don't know what to do." So we stop right there, hoping we'll feel better tomorrow or the next day, letting worry take over the management of our lives. Worry is a mighty confused manager. How much better it would be to get that physical examination today; find out if there *is* a problem in the first place, and if there is we'll know what it is.

Defining The Problem

Many of our "problems" are rooted in the nebulous fog of ungrounded fear and can be dispensed with by recognition of this fact. Defining the problem, pin-pointing the trouble, reduces worry to a minimum, saves energy for solving the problem and prevents the mobilization of harmful tension while the problem is being solved. The alcoholic's drinking has gotten him into trouble time after time. Family and friends tell him repeatedly that drinking is *the* problem. So he says, "O. K. I'll stop drinking." And he does—for a week, a month, six months. Then he goes on the longest bender yet. He had neither defined the problem nor solved it. He had merely postponed expressing the harmful energies created by the ever-mounting tensions from his real problems, as yet undefined.

Deep-Seated Problems

For the alcoholic, drinking is never *the* problem, just as compulsive stealing is not *the* problem of the kleptomaniac or compulsive eating *the* problem of the obese person.

Compulsive drinking, stealing, eating are symptoms of deep-seated emotional problems, problems which the victim always needs outside help in defining and overcoming. Emotionally maladjusted people must work harder and longer to develop

their problem-solving abilities than so-called "normal" people, but their rewards can be as great. Regardless of the stage at which a person's emotional growth was halted he or she can—by accepting whatever help is necessary in defining the real problems and then doing something about them in an organized, habitual way—achieve a higher degree of emotional maturity.

Evaluating Facts

Once the problem is defined the next step is to gather all pertinent facts and evaluate them. Here again our wishes and fears tend to distort the facts and confuse an objective evaluation. In addition this step demands more mental effort than the first. The football coach does not waste his time vaguely hoping to win next Saturday's game. He learns all he can about his opponent's strengths and weaknesses and evaluates them in relation to his own, plus taking into consideration the intangibles such as his team's attitudes. The successful problem-solver gets as many facts together as possible before deciding on the best solution and going into action. Even so, he has on occasion failed, but his failures have shown him at least where his fact-finding was not as complete as it should have been or where he failed to evaluate properly the facts he had gathered. His failures are stepping-stones to future successes; he doesn't waste his energy moaning over them.

Possible Solutions

After all pertinent facts are gathered, sifted, examined and evaluated, a course of action must be decided upon. This is where the going really gets rough. The ability to foresee possible and probable consequences requires an understanding of one's own personality strengths and weaknesses as well as an objective analysis of pertinent facts. Put the two together and try to imagine several possible solutions to the problem in order of both their desirability and probability. Only then are we in a position to choose the solution which seems best.

We are now ready to follow through with action appropriate to the situation. Our mental effort is wasted effort if we do not put our plan for meeting the problem into operation. Lack of courage and initiative to go ahead once we have decided on a solution is a far greater cause of failure than inability to figure out solutions. This, too, can be developed. Initiative is that form of energy used most by people who win and least by people who fail. Someone once cried, "Youth is a wonderful thing! What a pity it has to be wasted on young people." It's ironic perhaps that youth generally has more initiative and less judgment to solve problems while older people have better judgment but less initiative to follow through. Judgment comes from experience in thinking problems through to conclusions. Initiative comes from doing something about the mentally worked out conclusions.

Developing Initiative

The best time—although it is never too late—to develop initiative in solving problems, is childhood, when the wise parent helps his child to get into the habit of doing something about his own small problems as they arise. He teaches the child the nature of work, to experience joy in work well done, to finish every task that he begins. From such teaching on the part of the parent and such doing on the part of the youngster come constructive thinking and the energy of initiative.

It must not be overdone, of course. The child who has more responsibil-

ity than he can comfortably handle, more problems than his young intellect can solve, can become as frustrated in adult life as the one whose parents denied him the opportunity to work out problems. Both types are well represented in our courts, mental institutions and alcoholic treatment centers. If you would keep your children from joining the ranks of alcoholics, be the "wise" parent —and sprinkle your children's efforts liberally with praise and love for work well done.

The adult who just doesn't have the energy to work out the problems that bother him, who finds no pleasure in his work, who is always "too tired" to play with the children, to take the wife out occasionally, or to indulge in normal recreational activity, is only half alive; he's a sick man, especially so if he has developed a symptom such as alcoholism.

Mobilizing Energy

If he's sick he ought to see a doctor. Disease and old age reduce the mobilization and expression of energy to a minimum. If neither of these is present his problem is one of energy mobilization and utilization.

He needs to mobilize enough energy to reach established goals, and he needs to avoid mobilizing energy resulting from frustrations. This may seem contradictory but energy can be either "good" or "bad" for us; it depends on whether or not the energy is adequate to the situation. Too little or too much of anything can be bad, particularly energy.

Taking one extreme at the time, however, we will concern ourselves first with mobilizing enough energy to accomplish what we want to accomplish, remembering that our main sources of energy are: inherent constitutional energy, routine, habitual energy, and energy resulting from frustrations.

Assuming that we were not blessed at birth with an abundant supply of constitutional energy, let's move on to the next source and see what we can do about creating more habitual energy. How we work and how we play largely determines how much habitual energy we have. Habitually lazy people use very little energy and therefore have very little of it. There is also the man who works in spurts. Inspired temporarily by a sudden determination to "amount to something" he mobilizes enough energy to work furiously toward his goal, but the pace is too fast, the goal too far away, interest lags, and he gives up the idea until a new interest appears or the wife threatens to leave him or the boss threatens to fire him. When he is in one of these "work moods" he accomplishes a great deal and the quality of his work is usually high. In the long run, however, he loses out. The tortoise crosses the finish line ahead of the hare. It is the less spectacular but steady worker who is retained when others are laid off. It is the 50 MPH driver who arrives safely at his destination and the 80 MPH driver who kills himself on the way.

Work Steadily

The best way we can assure ourselves of the *right* amount of energy to accomplish those goals that our judgment tells us are possible to attain is to get into the habit of working steadily and persistently toward those goals. We teach our children to finish a task once it is begun, to accept the fact that work is inevitable and that they can learn to enjoy it by doing it in a routine, habitual manner with their sights set on the goal of accomplishment. We help them to develop their energy of initiative by forcing them to accept small responsibilities and solve little problems as they arise.

It is not too late for us to get into the same kinds of habits. It will take much mental effort to establish these habits, to "un-learn" old work habits, but persistence and patience can be richly rewarding. In time—months, years perhaps—as we have fewer failures and more successes we will have no need to worry about having enough energy, mental and physical, to do something about our problems. It will be there.

Avoiding Excess Energy

While striving to increase our constructive habitual energy we are faced at the same time with the problem of avoiding mobilizing excess energy that cannot be released through constructive, satisfying outlets. This is the kind of energy that is created by our frustrations, our unfulfilled wishes, our fears. All of us are familiar with it to a degree because none of us gets everything he wishes for, nor successfully avoids all anxiety about the future.

Since our bodies and minds automatically mobilize energy in proportion to the intensity of our wishes and fears we become tense when our wishes are thwarted and our fears remain with us. Tension is simply mobilized but unreleased energy. It is one of the greatest obstacles to problem-solving because it confuses thinking and makes life so uncomfortable that we lose perpective of the real problem in our search for relief from tension.

Harmful Tensions

The over-dependent, hostile, guilt-ridden alcoholic releases his tension by getting drunk and mistreating his wife or children or by getting into a fight at the local bar or by staggering into his boss' office and telling the old man what he really thinks of him, or by simply going on a bender until he has punished himself sufficiently. The ambitious wife whose husband is unable to make her dreams come true gets rid of her tensions by nagging or by developing an ulcer or other psychosonatic symptom. Thus the energy from frustrations is usually released in a harmful manner.

We can avoid mobilizing excess energy from frustrations in several ways. First, we can cultivate relaxed attitudes. Alcoholics Anonymous recognizes the importance of this in its slogan, "Easy does it," and "Live 24 hours at the time." The idea is to relax, not to collapse. We're collapsed when we say, "What's the use? I can't win, so I won't even try." Relaxation is the happy, positive medium between apathy toward goals and straining toward goals.

Limiting Our Wishes

We can also reduce the amount of mobilized energy by reducing the number and quality of our desires and fears. Everything that we want to be or do is not within our power. All of us are limited by opportunity and ability, so if we wish for things that are completely out of our reach we are consuming energy that could be put to a more practical purpose and are at the same time creating tensions through frustrations. If it seems certain that we are not going to be a Rembrandt, Pasteur, or Einstein, we can modify our wishes to the extent that we can work toward attainable goals and thereby reduce our excess energies.

Relaxed attitudes and realistic goals can reduce the mobilization of much excess energy but none of us can escape all of life's frustrations and resulting tensions. Nor would we want to. Were there no frustration we would have no incentive to succeed, no desire to learn anything, no wish to be happier or more contented than we are. The problem is to

reduce our excess energies as much as possible and express the rest through personally satisfying and socially constructive outlets, which are: intelligent verbalization, recreation, socialization and work.

Feelings Into Words

When we "tell somebody off" we like to think we're "letting off steam." Actually, we are creating more tension because we're just as angry at the end of the harangue as we were to begin with. Then we tell somebody else how we "told off" so-and-so, and the repetition either keeps us angry or makes us ashamed of ourselves when we realize we've been trying to hurt someone. That is not *intelligent* verbalization. We can let off steam much better by having a heart-to-heart talk with the person who angers us, by telling him we were hurt by his action, by trying to understand his motives for doing so, by trying to reach a mutual understanding on the matter, even if that understanding must be: "the next time this happens we're going to have to sue you." When we put our feelings into words designed to reduce instead of intensify our tensions we not only "let off steam" but we win respect for ourselves and usually improve our relations with others. This is the great value of talking over one's troubles and feelings with an understanding minister or psychiatrist. Since these therapists are not involved in the uncomfortable feelings, the feelings can be expressed more freely and without harm to anyone. The emotionally maladjusted person should always seek qualified help in draining excess energy from frustrations.

Recreation is essential to a well-balanced life. Play builds up physical energy and also helps to get rid of harmful tension. The businessman has had a hard week at the office. A competitor has taken an unfair advantage of him and he's a little peeved about it. He knows that 18 holes in the brisk fall air will tone up his muscles and tone down his tension, but the main reason he plays golf is that he likes golf.

He doesn't realize, nor does it matter, that his smacking the golf ball is a good substitute for smacking his competitor. It drains the tension arising from his hostility. Whatever sport or exercise you enjoy, do it often and regularly, but do it for fun; don't made a chore of it.

Socialization is the most universally used method for releasing tensions. The withdrawn person loses perspective of his problems. He has a tendency to brood and worry, which increases his tensions. As alcoholism progresses, the alcoholic becomes more withdrawn from society; he gets out of contact with the world in which he lives and his misery increases. That is why socialization is so important to the continued sobriety of AA members. They get together often. Some of them attend three or more meetings a week because they know from experience how tensions multiply in loneliness.

Tension-Relieving Work

But we must go a step further in our efforts to reach our potentials in satisfying, constructive living. No device for relieving tensions is as good, as effective, as creative as work. You may know someone whose personal misfortunes have been so many and so tragic that you cannot understand how he survives. The chances are that no matter what happens he never loses his faith in tension-relieving, constructive work.

I know a man whose wife had died after a lengthy illness and left him with a baby, a debt of $10,000, and a bankrupt business. He did not throw up his hands and say, "What's the

use? I'll never get out of this." He studied the problem, decided on the best possible solution, and worked steadily toward his established goal.

At first he sold soap, later blankets, from door-to-door because they were the best jobs he could get at the time. He assured his creditors that eventually they would be paid back every cent on the dollar. And they were—in less than ten years because he had defined the problem, gathered the facts, decided on a possible solution, and worked steadily toward a distant but attainable goal.

Good work habits generated the energy he needed and also released the tensions from his frustrations. Today he is the head of a large and very successful corporation. He had a plan which he habitually used for working out his problems. He has had failures, yes, but his successes have outnumbered them. In the long run that's what counts, isn't it?

A Physician Looks At Alcoholism

(Continued from page 15)

training in therapy. The general practitioner with a world of patience, a kindly and receptive attitute, constant availability, wholesome understanding and encouragement—and a bare modicum of sedation, fluids and vitamins—can do more in less time than a well-equipped hospital with a hostile staff, and with far better results. It follows, then, that *a receptive staff in the well-equipped hospital* can work real wonders of recuperation, with unrivalled opportunity to encourage additional aid through local AA groups and the ministry. Further rehabilitation through appropriate centers, and psychiatric guidance in private or clinic conference can round out a well-balanced program for any community.

Within the past year, it has been my privilege to read articles by, and to study under the guidance of a psychiatrist who readily acknowledges God, and his awareness of the fundamental necessity that an alcoholic must first experience a conversion of genuine order if he is to stand a chance of achieving permanent sobriety. This conversion is recognized by many, both in religion as well as in medicine, as similar to the humility of surrender manifest by the atheist or agnostic in the acknowledgement of a Higher Power.

Faith Into Practice

It is impressive that most physicians not only are members of churches of organized religion, but often hold offices of high responsibility in the church. Since this is true, how much greater is our debt, spiritual as well now as professional, to minister to the alcoholic, whose illness is spiritual as well as physical. As we practice medicine, we must without hesitation represent to the patient this consistency of putting our own faith and spiritual profession into that practice.

It is most emphatically not the province of the physician to explore dogma or creed, or to instruct in theological matters where there is conflict in the patient's mind. But we do have the persuasion of our own faith that we act in the spirit of "Love thy neighbor", and "Do unto others", trying always to meet the patient's faith with the frank acknowledgement of our own reliance on a Higher Power. This is neither sanctimoniousness nor prudery, but rather an honest and honourable means of securing the firmest of rapport, bedrocked and cemented in measures of mutual faith.

Books of Interest

MANAGEMENT OF ADDICTIONS

Edited By Edward Podolsky, M.D.

Philosophical Library
New York
$7.50

THIS book consists of 35 chapters (26 on alcoholism, 9 on drug addiction) by a multitude of authors. The student of the subject will readily recognize many of the articles as they have already appeared elsewhere, although this is not expressly stated in each instance. It would be helpful if the original date and publishing journal could be indicated at the beginning of each chapter.

The selections from the literature are fairly recent. Unfortunately the editor has failed to include any reports on chlorpromazine and reserpine. Even some of the preliminary findings with these new drugs would have been valuable, and their lack makes the book already out of date in this respect.

Inevitably a book with such a multiplicity of authors leads to the presentation of conflicting opinions and tedious repetitions. (An extreme example is Chapter 24 which repeats in more detail what the same author said in Chapter 23.)

After an excellent four-page foreword we see no more of the editorial pen. The chapters fall into no particular order and we find an early chapter commenting upon previously published work which only appears in a later chapter of the book.

About 40 pages are devoted to Williams' genetotrophic theory of alcoholism. Surely, then, some space might have been used to report the failure of Lester and Greenberg to confirm Williams' experimental work.

Drawing as it does many levels of psychiatric and medical thought the book presents some notable articles. In particular one recalls those by Higgins, Lolli, Gottesfeld and Yager, Thimann, Diethelm, Knight and Prout, Arora and Sharma, and Pescor. Many of these chapters go beyond the strict question of management of addiction.

We are told that the book is primarily for physicians. However, if the inquiring physician turns to the book hoping to learn how to manage, say, an alcoholic patient, he will be faced with a wide therapeutic choice —diet, hormone, conditioned-reflex, mebaral, CO_2, calcium, tolserol, antabuse, and barbiturate therapies, etc., not to mention hypnotherapy and, of course, psychotherapy. These therapies are offered enthusiastically but rarely critically, and controlled studies are noticeably lacking. Our inquiring physician may feel he has opened Pandora's box! His task would have been easier had the editor been more selective and willing to add some editorial comment and criticism throughout the book.

The section on drug addictions is brief and Wikler's views are completely omitted. This is surprising in view of the fact that the editor has drawn upon them liberally in writing the foreword.

There are quite a few misprints and the book seems overpriced.

—John A. Ewing, M.D., D.P.M.
UNC School of Medicine

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

NOV.-DEC., 1955

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

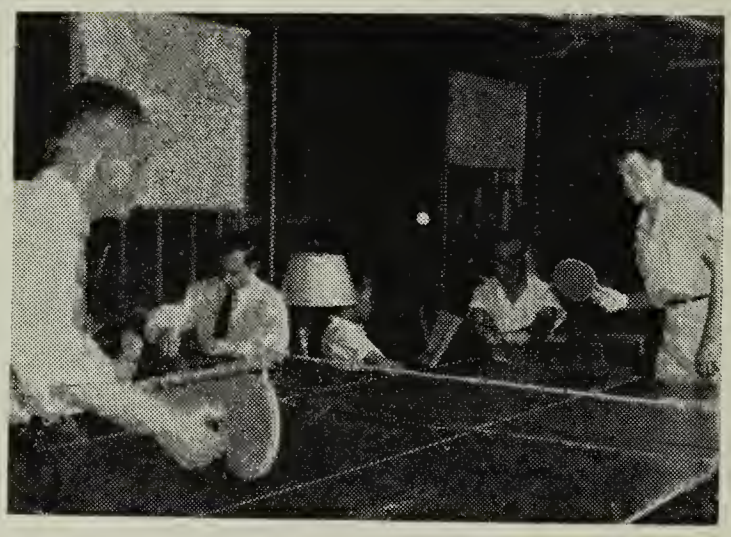
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center has a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM
OF THE
NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

LORANT FORIZS. M.D.
Clinical Director

INVENTORY

VOLUME V NUMBER 4
NOVEMBER-DECEMBER, 1955
RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

Friend Rehabilitated

Although I am not an alcoholic I am vitally interested in the problem and have recently witnessed what a great influence the Rehabilitation Center at Butner and our local AA Chapter has had upon a very close friend of mine. He was once a "wreck" but is now an asset to our community.

Again let me congratulate your staff for the good job they are doing and I pledge my assistance in any effort which you might undertake.

Attorney at Law
Elkin, N. C.

Thanks To Butner

This year past has been a very wonderful experience for me. It has not only been the longest period of sobriety I have known in years but it has also discounted a thought I had harbored for quite some time, and that was, happiness for me was out of the question.

I have found that by doing something I thought was the craziest thing I had ever heard: "Just do sober what you got drunk to do," said by a wonderful person in my opinion, Dr. Lorant Forizs, alcoholics can be happy and have peace of mind. I have met and become friends with many wonderful people thru the AA program. So I say again and again, Thanks to the ARC Center at Butner, its wonderful personnel, for its helping hand towards me and to the Grace of God and the AA program for helping me so much when I needed it most.

Conway F.
Charlotte, N. C.

Can Face Life Now

I have learned how to face life and responsibility and to leave alcohol alone when I have troubles. Alcohol only makes things worse.

I learned a lot from going to Butner. It's a wonderful place for people like I was that needs treatment. I just hope and pray that every one that goes there can get as much good out of it as I did. I can face life now and responsibility, but most of all I have my family back and we are very happy. Thank you very much.

Jack B.
Winston-Salem, N. C.

NCARP Material Best

We consider your material the best that we have found anywhere for general purposes. We have used it a great deal in supplying information about the alcohol problem to students of university, Normal School and high school, for their information in writing essays and theses. Information supplied to such students must be entirely objective and factual and we have found your material ideal.

Miss Marion B. Paton, Sec.
Alcohol Research and Education Council
Vancouver 9, British Columbia

AA Auxiliary

Our women's group of non-alcoholics, but who are all wives of alcoholics want you to know how very much we enjoy INVENTORY. It has helped so very much and we surely look forward to each issue. When the new copy comes, it is used at the next meeting and really appreciated.

Mrs. Edna R.
Madison, Wisconsin

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

DURING the first two weeks in October our staff participated in a unique educational campaign in Asheville.

For the past several months, the Asheville Citizens Committee on Alcoholism had been laying careful plans for an educational effort which they hoped would alert western North Carolina to the problems of alcoholism. Instead of the usual approach to a community institute on alcoholism, the Asheville group used a new one. This involved getting speakers before a number of so-called "captive" groups in the community rather than depending on a few larger public meetings to get across their alcoholism message.

Under the direction of Dr. F. Stuart Chapin, chairman of the Citizens Committee, the members contacted practically all civic, church, and professional groups holding regular meetings in Asheville and the surrounding area, and asked if they would care to schedule a speaker for one of their regular meetings.

60 Speaking Engagements

The response was tremendous and by the first of October some 60 speaking engagements had been scheduled.

The NCARP staff had agreed earlier to handle the speaking for the Committee, and we were happy to do so. It was necessary for Dr. Kelly, Miss Lytle, Mr. Adams, and I to be in Asheville for the entire two-week period, during which time we spoke to a total of more than twenty-five hundred people, representing a wide variety of groups.

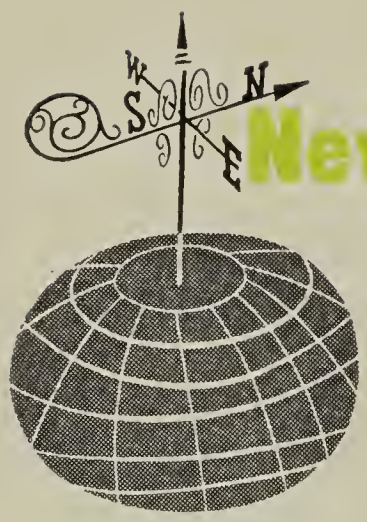
A typical day's schedule included talks before the Asheville Optimist Club, the Asheville Rotary Club, YW Wives, Hendersonville Kiwanis Club, Biltmore Lions Club, Valley Springs Grange, the Asheville Mental Hygiene Clinic Board, and the Junior Chamber of Commerce. At various other times we were privileged to speak to groups of ministers, social workers, nurses, druggists, dentists, and to the supervisory personnel of a large industrial plant. A television program and an open public meeting rounded out the series.

Saturation Campaign

The Asheville program represented an attempt to "saturate" people in the area with accurate information about alcoholism, and to stir up interest in the efforts of the Asheville Citizens Committee on Alcoholism. I think it was a highly successful effort. Dr. Chapin and his Committee members are to be commended for the excellent way in which they planned and staged the entire campaign.

But the Committee does not intend to rest on its laurels. They now face the problem of mobilizing the public interest which has been stimulated and using it to add impetus in mov-

(Continued on page 31)



News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

NEW DRUG REVEALED

UNITED STATES. The search for drugs which can help alcoholics avoid serious withdrawal symptoms and also serve as a valuable adjunct to psychiatric treatment has revealed a new interneuronal blocking agent which may prove to be helpful in most cases. Named Miltown (2-methyl-2-**n**-propyl-1,3-propanediol dicarbamate), it "produces relaxation of skeletal muscles without affecting respiration and other vital functions and also has important effects on the brain." It was given to 187 patients with anxiety neuroses, including 10 who were alcoholics. Treatment lasted between 1 and 8 months. Favorable results were achieved in 9 of the 10 alcoholics. The report in the **Journal of the American Medical Association** stated that Miltown "helped to avoid serious withdrawal symptoms and assisted in keeping the patients sober after withdrawal was completed."

METHODIST CONFERENCE ENDORSES AA

NORTH CAROLINA. In the approved Report of the Conference Board of Temperance, 1955 Session of the N. C. Conference of the Methodist Church, Fayetteville, N. C., it is suggested for the first time in history that their pastors provide meeting places for AA Groups, although it has previously commended the activities of AA. The report states, in part: "In many communities, they (AA) need a place in which to hold their weekly and semi-weekly meetings; and we recommend that our pastors cooperate in providing meeting places for AA Groups. We recommend also that all pastors and other church leaders familiarize themselves with the program of Alcoholics Anonymous; that they invite qualified speakers from this organization to address Sunday School classes and other groups in our churches; and we recommend that our pastors and other members cooperate fully with the local units of Alcoholics Anonymous."

ALCOHOLIC REHABILITATION SINCE 1909

NEW ZEALAND. In 1909, at the request of the Government, the Salvation Army established on the island of Roto Roa in the Hauraki Gulf an institution to rehabilitate committed and voluntary inebriates. Rehabilitation methods there have been flexible, but in general the Salvation Army stresses recreation, occupational therapy, hobby skills, and socialization, as well as spiritual rebirth, remarkably similar to treatment methods, with variations, used in therapy in the United States today. Patients remain from 6 months to a year at Roto Roa. Although reliable figures on recovery rates are not available, it is claimed that 70% do not return to Roto Roa, an indication at least that most of them do not reappear in the courts.

CONSISTENT DECLINE IN ALCOHOL CONSUMPTION

GREAT BRITAIN. The average Englishman seems to be drinking quite a bit less than he used to. Observers have noted the consistent decline in alcohol consumption there for more than two decades. In 1900, for example, 38 million people in England quaffed 36 million barrels of beer. In 1953, 50 million Britishers drank only 25 million barrels. And they drank 40 million gallons less beer in 1954 than they did in 1953—without any appreciable rise in the use of gin, whiskey, and rum.

VIRGINIA PROGRAM GETTING GOOD RESULTS

VIRGINIA. According to a report from the Division of Alcohol Studies and Rehabilitation of Virginia a majority of its alcoholic patients have either recovered or improved their condition. Of the 1,687 patients treated between 1948 and 1953, 26 per cent have remained abstinent since beginning of treatment; 15 per cent have maintained sobriety after 1 relapse; 28 per cent have improved in general; and 31 per cent have remained unimproved.

NSCA WILL MEET IN TORONTO

MIAMI BEACH. The National States' Conference on Alcoholism, an organization made up of representatives from the various State Programs on Alcoholism, met here on October 30 to be brought up to date on the latest scientific findings and to discuss with one another progress, problems, and plans. It was announced that next year's NSCA will be held in Toronto, Canada, at the invitation of H. David Archibald, executive director of the Ontario Alcoholism Research Foundation and highly respected man in his field.

COFFEE DRINKING, WHISKEY DRINKING AND COLD SHOWERS

CHICAGO. Two bits of news gleaned from the pages of **Today's Health,** the popular magazine of the American Medical Association, should be of special interest to AA's. One bit concerns coffee drinking. It is claimed that you can probably drink 20 to 30 cups of coffee a day without harm if you're perfectly healthy to begin with. The caffeine in coffee, however, can cause tremor, nervousness, insomnia, headaches and other small difficulties for some people. Excessive coffee also can be harmful to people with heart, nervous or intestinal disorders, it is reported. The other news destroys another popular fallacy about alcohol. "Taking a cold shower," says Dr. Frederick A. Fuhrman, Stanford University physiologist, "doesn't speed up making one sober after drinking too much—it slows the process down. The lower temperature induced by cold water slows the action of alcohol and other drugs."

PROGRESS IN BUSINESS AND INDUSTRY

NEW JERSEY. The du Pont Company, a leader in instituting rehabilitation measures for alcoholic employees, has issued a report stating that over a period of 10 years 350 employees (65 per cent of those treated) have been rehabilitated. When it is obvious that an employee has a drinking problem his immediate supervisor refers him to the medical division, where he is examined. It is explained to him that he has a disease which is interfering with his life and chance of success. Treatment is offered and he is urged to join AA. If the patient does not recognize his problem during the course of 3 months, he is dismissed. The company estimated cost of the program at less than $100,000. Total gains cannot be measured.

THE PUBLIC WILL BE SERVED

MANY of you have been writing us for copies of *The New Cornerstones* and other booklets and reprints published by this Program which we have been unable to supply in recent months due to severe cuts in our printing allotment. Our supplies of these items are now, almost without exception, exhausted.

As we go to press with this issue of *Inventory,* however, we receive word from Mr. D. S. Coltrane, Assistant Director of the Budget for the State of North Carolina, that he is allocating additional printing funds to the Program so that we can continue to meet the demands of the public for factual, objective information on alcoholism. While it is doubtful that these additional funds will be adequate for publishing everything we had planned, we will be able to furnish satisfactory quantities of those materials considered most essential. Needless to say, we are extremely grateful to Mr. Coltrane and this wonderful State of North Carolina for the opportunity to continue our education-information work at or near our previous level of activity.

NCARP Publishing Plans

We'd like to tell you about our publishing plans for the next few months. First, an order has been given to the press for reprinting *The New Cornerstones.* The new printing will be available for distribution by January 1, 1956. A new, revised brochure on the Treatment Center of the N. C. Alcoholic Rehabilitation Program at Butner should be available shortly thereafter. By early Spring we will have available for distribution to the clergy a booklet which many of our clergymen have asked us to publish. Written by ministers and pastoral counselors of several denominations who have deep understanding of the spiritual problems involved in alcoholism this booklet will be used as a guide in the pastoral counseling of alcoholics and their families.

If our money holds out we also plan to publish a booklet pointing up the problem of alcoholism in business and industry. This booklet will be directed to business leaders and their supervisory personnel and will offer suggestions for coping with problem drinker employees.

Additionally, we will review and combine closely related reprinted materials which have been most requested. As the new

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VOL. V, No. 4 INVENTORY NOVEMBER-DECEMBER, 1955
ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

THE ROAD TO SOBRIETY

Accurate knowledge plus a deep spiritual awakening are the first steps.

BY NORMAN F. THORNTON
HEREFORD, ENGLAND

TWENTY years ago, the alcoholic was a figure of suspicion to the general public, a baffling "case" to legal, ecclesiastical and medical authorities alike, and an unholy terror to his or her spouse, family and friends. In an official survey of those days it is written that when the vicious, powerful craving for alcohol came upon its victim, his only chance of salvation from the dreadful consequences of imbibing, was to report to the nearest hospital as a voluntary patient for the purpose of being forcibly restrained from taking a drink.

Today, the picture is very different indeed. Alcoholism is now recognized as a social disease, in some countries giving cause for grave concern to the health authorities. No longer is the alcoholic a baffling phenomenon in society to the experts. Nor is the time very far distant when the general public too will know from articles in the press and from public meetings to be held throughout this and other countries, the difference between an alcoholic and an ordinary heavy drinker and the causes, symptoms and remedial treatment of alcoholism.

It is no exterior force that compels the alcoholic to drink, but the force of the disease within him: the restlessness, discomfort, tenseness and irritation which he feels about life in general, and which is unfortunately the deep-seated, psychological justification for his terrific alcoholic excesses. Moralists of both Victorian and present times have been known to scorn and even revile the alcoholic, a misanthropic attitude that—far from curtailing the excesses—served as a powerful incentive to the victim to increase his drinking.

Alcoholism is a progressive disease,

not easily recognizable in its youthful signs, except of course by experts devoted to the social work of reducing its toll of human lives. In its later stage, it becomes so sharply evident to those who know the victim that they are often frankly horrified and at a loss as to what to do. At least, that has been the general picture until recently when community resources for the positive treatment of the disease have become increasingly available. Advanced alcoholism has been compared to "a state of death as real as that from which Lazarus rose only by a miracle." Recovered alcoholics can admit the simple veracity of this analogy. They know, and those who know them know, it is no hyperbole.

Trick Of Transformation

Indubitably, the existence of alcoholism is acknowledged nowadays far and wide enough. Even so, there are still too many too prone to exhort: "The remedy is simple, man. ABSTAIN!" The inference being of course that will power alone can do the trick. How thankful our health authorities would be, were it really as simple as this! Unquestionably, had the trick of transformation from a state of torturing intoxication (painful poisoning) to one of healthy, happy sobriety been so absurdly simple then would social bodies for the treatment of alcoholism neither have been born nor prospered.

How gladly would any alcoholic upon many a desperate occasion in the past, have renounced liquor and stayed sober by will power. This is the cardinal point those will-disputants overlook. They but perceive the surface of the problem, happily oblivious to the whole truth that alcoholism attacks the whole person, bodily, mentally and spiritually. However, alcoholics do have to firstly stop drinking before their wounded organs, their undermined will power, and their warped philosophy can begin to recover.

Ready For Treatment

One man's meat is most certainly another's poison. Beer, to many a person, is a wholesome, harmless beverage. Not so to the alcoholic. Even a pony of mild beer is a poison to him. For that small pony of much-diluted alcohol will result, sooner or later, in yet another senseless debauchery. It is when alcohol has long ceased to occasion its user its earlier enchantments; when he drinks in the full knowledge from repeated bitter experiences that his gloom will but deepen, and irritation at life increase; when he knows that he is now an anti-social drinker, having lost the power somewhere along his drinking career to say, "No more now, thank you. I'm off home. See you tomorrow."—It is when these symptoms are glaringly manifest that he is ripe for initiation into the treatment offered by those societies dealing exclusively with this disease.

We know that there are iron constitutions, steel nerves and granite heads whom scarcely any excesses can injure, apparently. Their resistance to alcohol can be measured

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IT'S WHAT YOU DO WITH IT THAT COUNTS

ONE of Ripley's famous cartoons pictured a plain bar of iron worth $5. This same bar of iron when made into horseshoes would be worth $10.50. If made into needles, it would be worth $3,285, and if turned into balance springs for watches, its worth becomes $250,000. The same is true of another kind of material—you! Believe it or not!

MOTHERS, WIVES, and ALCOHOLICS

There's a reason why alcoholics often marry women who will "mother" them.

BY LORANT FORIZS, M.D.
CLINICAL DIRECTOR,
NCARP REHABILITATION CENTER
BUTNER, N. C.

IN emotional and personality development, all individuals go through an oral stage. After breathing, our first contact with the outside world is through the mouth. This means sucking, and that immediately means mother. Mother again immediately means a feeling of dependency or some sort of an awareness of dependency. Dependency on mother undergoes a great number of conventional frustrations, and we start to develop some sort of independence in getting away from mother. This would mean leaving the oral plane and trying to operate on a higher level of development. If something goes wrong on the new level of adjustment, the person is likely to regress and act out or gratify himself on the last previous level, which in this case, let us say, is the

oral phase.

We find that the alcoholic has a great deal of difficulty there. I do not want to use absolute terms, but it is safe to say that in many, many cases of alcoholism the patient had difficulty with this switch-over from a feeling of security through dependency to a feeling of security through independence. We find that the alcoholic, in most cases, is a great deal over-dependent on his mother and stays so for some reason, for a considerable length of time. The degree is great, although sometimes the length of time may be shortened, even on this side of the normal.

Perhaps if the feeling of over-dependency is too great the individual will try to do something about it—try to compensate for it. He might make a desperate attempt to be overly independent. In many cases of alcoholism these two features, either a prolonged dependency or an early switch-over into the extremely independent pattern, occur frequently.

Too Much Like Mother

We say then that when the fellow is having difficulties on the oral level, which is tied in with the mother, he might feel that he is too much like mother.

Conforming with the dreams of mother will mean too much identification with her and her principles, her ideas, her criteria, thereby making himself a little bit too much like her. In the case of a man, it will at a very early age and in a very disturbing manner create a feeling of being a sissy. "If I am too much like mother then I am too feminine. I cannot tolerate that because I do not want to be anything else but a masculine male. I can't take it to be feminine; I can't take it for my own self-respect and because of the general attitude of the whole environment. They will call me a 'sissy' and that means inferiority. Knowing this, I may decide to be overly masculine. The threat of something being missing in the sexual identification line will make me overly masculine and I will make a desperate attempt to prove that to myself. The most obvious and easiest way to do this would be to go out and conquer as many females as I can conquer in the most complete form—that is, sexual intercourse with as many women as I can. Those women quite obviously won't be the nicest type of girls."

Promiscuous Feature

Hence the tremendous number of case histories in which one hears about the patient having been a complete "sexual athlete" long before he had touched alcohol. This is the rather pronounced promiscuous feature of the alcoholic's early life which I believe very few people will deny. "Because I am too attached to my mother I obviously am dissatisfied with her, but I can't break away from her. Perhaps it would be sort of a revenge not to pick a similar type of woman, so I will take the opposite type." It is noticeable how much difficulty some men have in their late adolescence with the nice

THE most lovable quality any human being can possess is tolerance. It is the vision that enables one to see things from another's viewpoint. It is the generosity that concedes to others the right to their own opinions and peculiarities. It is the bigness that enables us to let people be happy in their own way instead of our way.

Dr. Lorant Forizs

This article will be Dr. Forizs' last as Clinical Director of the NCARP. He is moving to Florida to become Clinical Director of the Florida Alcoholic Rehabilitation Program.

Skilled clinician, able administrator, dynamic speaker and teacher, Dr. Forizs has contributed much to our understanding of alcoholism as an emotional illness. He will be greatly missed. The NCARP wishes him continued success in his new position.

type of girls. "No, I can't go with them; they are too much like mother, and getting too close to mother is dangerous."

I don't want to go into the Oedipus complex here, but I think it is fairly obvious that it has something to do with it. Let us just say that mother, perhaps through her over-protectiveness and over-indulgence, keeps the boy too dependent on herself. Consequently, the personality type that mother has becomes intolerable for him. She keeps him a sissy; he was only her baby; therefore, he picked the easy type of girl and obtained the characteristic which is so prevalent in the early history of the alcoholic: promiscuity. He cannot adjust to the nice girls. As soon as he is confronted with them he will get shaky and apprehensive. Many boys will take alcohol during the adolescent phase just to overcome their concern with girls in general.

I have already implied that over-dependence on mother is resented. This is an important fact. This resentment is some form of aggression, and it would be worthwhile to analyze it a grade or two further. This aggression is directed against the female figure. The first female figure in our life is our mother. It is in connection with her that we lay the foundations of our emotional structure. Our relationship to her will be transferred to many aspects of our whole relationship with the entire female sex.

Alcoholic Paranoia

From the social history of the alcoholic, we get another important observation. Let us take another feature of alcoholic psychosis, alcoholic paranoia. We see that in an overwhelming number of alcoholic paranoia cases, the delusions or hallucinations will be centered around the faithfulness of the wife. The mechanism of the alcoholic paranoid's thinking is this: "I don't like women; I've had too many bad experiences with them—first of all with my mother—so I cannot take them. But if I cannot take them then I am not going to be masculine, I am going to be feminine. I cannot tolerate that, so I will try to be over-masculine. In other words I have a lot of promiscuous trends in myself. If I happen to have a wife she will be so much above me, higher in her moral values, and that puts me in a low position. I cannot keep her up there. I will try to pull her down. I will project my promiscuity onto her. I am no good, but neither is she. I cannot master myself so I will have to attack her. The most feasible means of attack would be to project my promiscuity onto her. In fact, I have no other weapons. Perhaps I am so much on the promiscuous side that I cannot make that confession even

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New Hampshire's Division On Alcoholism

One of the first states to recognize the seriousness of its alcoholism problem, New Hampshire has developed a balanced program of treatment, education, research, and community organization.

BY HAROLD W. DEMONE, JR.
EXECUTIVE DIRECTOR

JUNE 30, 1955 marked seven and one half years of operation for the New Hampshire Division on Alcoholism; the first two and one half as an independent agency, the remainder as a division of the State Department of Health.

The legislation establishing the Division states, "The purpose of this act is to (a) assist in the control of the effects of alcoholic beverage consumption present in alcoholism, by the establishment of a state program for medical and other scientific care, treatment and rehabilitation of inebriates, (b) reduce the number of inebriates through education and information, (c) study the causes and effects of alcoholism, and (d) permit and encourage cooperation from public and private agencies engaged in the alleviation and study of alcoholism and the care and treatment of inebriates."

It all began back in 1944 when three New Hampshire residents who were concerned about the state's alcoholism problem attended the Yale Summer School of Alcohol Studies. They returned with the firm conviction that the new socio-medical information on the subject gave hope that some of the ravages could be controlled.

Detailed Survey

They took this message to the 1945 Legislature which in turn established an Interim Study Committee with orders to report back in 1947 with their findings. After a careful and detailed survey of the New Hampshire situation this committee not only returned a strongly worded recommendation that a permanent state organization be established to combat the problem in New Hampshire, but energetically and successfully brought about enactment of their recommendations.

N. H. Division officials are (l. to r.) Harold Demone, Director; Henry Musnick, M.D., Clinical Director; and Camille Lambert, Chief Social Worker.

Following this herculean task, in 1947, the Board for Treatment of Inebriates was established, with Ernest A. Shepherd, the leader of the struggle, being selected as executive director and a board of interested citizens, now a commission, was appointed by the governor.

Factors In Success

These two factors, the appointment of a dynamic, capable executive director and a concerned, forceful board, combined with the cooperation of New Hampshire's citizenry and consultants from the Yale Center of Alcohol Studies were basic to the almost immediate success that the program enjoyed.

From that time through June 30, 1955, 1269 individual patients were seen, 760 on an active basis, and 509 on a preliminary basis. Over 350 speaking engagements have been filled, close to 100,000 pieces of literature have been distributed and hundreds of film showings and interpretations have been made.

"The alcoholic is a sick person who should and can be helped." Operating under this very simple hypothesis New Hampshire as well as many other states in the United States have established programs on alcoholism in the past 10 years. New Hampshire is proud to have been among the earliest since we feel that this nationwide growth is one of the major public health achievements of the 20th Century.

Although the Division had outpatient clinics from its inception, during the early years it had no hospital facilities of its own. Instead, beds in New Hampshire's state mental hospital were utilized until April of 1952, when the first inpatient service (8 beds) devoted exclusively to New Hampshire's alcoholics, was opened in a wing of a general hospi-

tal in Concord, New Hampshire. The result was an immediate and sharp increase in the caseload of the Division, with 907 admissions from the opening of the service to June 30, 1955. In 1953, 277 were admitted; in 1954, 264 and in 1955, 323. Further analysis of the case data indicates that about 90% of these admissions occurred first as inpatients, the other 10% as outpatients. In addition, in any year, between 60 and 70 patients will be carried over in outpatient treatment from the previous year.

24-Hour Basis

The Division on Alcoholism is not a general hospital nor it it an institution for the insane. It is not equipped to handle patients with severe medical problems obscured at first by acute or chronic alcoholism. Nor does it have the facilities or staff to handle severely disturbed patients who might be suffering from the D.T.'s, alcoholic hallucinosis or psychosis or Korsakoff's syndrome. It does, however, accept patients drunk or sober on a 24-hour basis. The only requirements are that the individual (1) be a New Hampshire resident, (2) not be psychotic and (3) there be available space.

Composite View

A profile view of the average patient based on an analysis of admissions to the New Hampshire Division on Alcoholism for the fiscal year 1953-54, is as follows: This patient was a male on 6 out of 7 occasions, age 40, with between 10 and 11 years of formal education. The chances were about equal that he was Roman Catholic or Protestant. He was not a veteran, came from a family of five children, was married and living with his wife and was employed in a semi-skilled or unskilled capacity. He had a 50-50 chance of having had alcoholism in his immediate family, was a voluntary patient who was referred to us by either his doctor, an AA member, or himself. He was interested in AA, was in the crucial stage of alcoholism and has never been previously admitted to us for treatment. While in treatment he was seen by the doctor, psychiatrist, and social worker on about 18 different occasions during the year and had about three chances out of four to show some signs of improvement.

Therapeutically, various techniques are used: individual and group psychotherapy, (both insight and supportive), recreational therapy, occupational therapy, Antabuse therapy, audio-visual aids, vocational counselling and the various new medications including Thorazine and Serpasil.

A very careful attempt has been

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"It's a little something to occupy your time while you're drinking."

IT'S MY OPINION

THIS DEPARTMENT IS FOR THE USE OF AA MEMBERS WHO DESIRE TO EXPRESS IN 300 WORDS OR LESS THEIR IDEAS, OPINIONS, AND PERSONAL EXPERIENCES. ARTICLES FROM AA'S UP TO 2,000 WORDS WILL BE CONSIDERED FOR PUBLICATION ELSEWHERE IN INVENTORY.

THE road to permanent sobriety is not only a very hard one but also a road that is very strenuous and very often both dangerous and extremely slippery.

It suddenly struck me today, after 3 years' sobriety, that I still have not gone very far upon the new road of life. In fact, I've only just reached the First Plateau, and my foothold is as yet far from firm.

Well, I've come that far. I can now, with some feeling of security, afford to survey the road I have travelled, the road which led up from a valley of destruction, iniquity and degradation. The First Step says: We admitted we were powerless over alcohol, and our lives had become unmanageable. The very simplicity of that statement has often staggered me.

From what I myself can dimly remember, but mainly from reliable observations by others, I can now plainly see that at least the first 12 months of my sobriety were the most dangerous months of my entire existence. During that time I must have been—quite unbeknownst to myself—equal to a helpless child in many respects. I was being watched, guarded and coaxed with gentle but firm tactfulness.

This is no easy matter to frankly admit, especially for an old seaman like myself. Seamen are about the most independent and self-reliant type of men, afloat or ashore. I've often heard that the First Step is the most important. Well, I'm not prepared to offer an opinion. I do know, however, that the other human who helps us when we take the First Step is the most important person in our lives.

Bill P.
Wellington, N.S.W.
Australia

ALCOHOLICS are men or women who cannot control their drinking. They cannot take it or leave it. It doesn't make any difference what it is: beer, wine, vodka, cough syrup. They cannot treat it like any other beverage: coffee, tomato juice, or what have you. A double shot of whiskey, then a compulsion and obsession sets in over which they have absolutely no control. Will power is not a factor. It has nothing to do with the problem. It is addiction. And as time goes on its strength is like that of a wrought iron chain. An alcoholic and a drunk are two different things. Being an alcoholic is serious business. The end result, unless something is done about it, is insanity or death. It is fatal.

All about us in AA is living proof that a man can stop drinking, no matter how far down he has gone, and return to take his place at home and in society and, what is infinitely more important, win back his own self-respect and confidence. He can be comfortable and happy about the

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GENTL
DOUR
CHAMPION

AN OPEN LETTER TO AN ALCOHOLIC—

HOW AN ALCOHOLIC CAN HELP HIMSELF

Somewhere, someone with a drinking problem will read this letter—and be started on the road to recovery.

BY AN ANONYMOUS PRIEST

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DEAR Ben: For the past two years I have known that you were wrestling with the problem of alcoholism. As you know, your wife has spoken to me about it and has informed you that she discussed the matter with me and urged you to do the same. You did not then, and have not since, so I must presume that you intend solving this problem by yourself.

As your minister, may I extend this unsolicited advice, knowing in advance that it might not be heeded but feeling compelled to do so as part of my pastoral responsibility to you.

I remember all too vividly writing a parishioner some years ago telling him that he must come to talk over the problems in his marriage stating that my own evaluation was that his marriage was near the point of rupture. My evaluation was tragically correct, for he picked up this letter in the mail box the next day, and entered the house to find a note from his wife stating that she had gone home for keeps.

A minister must choose between offering advice when it is not requested, and living with his own conscience, knowing he should help —but finding no channel of communication with his parishioner, save something of this kind. You may answer this letter, or ignore it and we will never mention it, but since you are not seeking help in this problem I feel I must write from my own experience and tell you what an alcoholic can do to help himself.

The first thing that is required, if an alcoholic is to help himself, is to face the problem. Most alcoholics resist counseling. That is quite natural, for few persons understand an alcoholic. The wife or husband is generally hostile. Friends plead with you, parents cry over you. Doctors are often cynical or indifferent and social workers disgusted. Some ministers are horribly sentimental or condemning in their attitude toward you. You have had so much poor advice from "Job's counselors" there is little wonder you avoid counseling at the present time.

But if you function as 101 per cent of alcoholics you have built up in

your mind a wall of rationalization. It is the only thing worse for you than the advice you get. The alcoholic justifies all his actions in his own mind. It's the wife's fault, his mother's, the nature of the job, or maybe it just got dark early today.

In addition to rationalization there is always the counterpart, called the "alibi system." There was a time in my young son's life when he always gave a reason for his own failure by stating what was at fault, other than his own inability to achieve the desired result. As long as you keep an alibi system running a parallel to your rationalization, you simply cannot face the problem and therefore it will not be solved. The greatest fallacy in the alibi system is that you take over the responsibility of giving up drink on your own, then it's your baby and you cannot blame others for not helping you.

Reason For Drinking

I realize, however, that there is a reason for your drinking. I know that it gives temporary relief, that it has it's own reward; that more specifically it solves for the time being all your problems. Non-alcoholics cannot understand this. They have never experiencd the feeling of anguish, frustration, and despair that you know will disappear if you only get those first two or three drinks pulsing through your blood. But I also know that you have tremendous periods of remorse when you do sober up. I realize that you want to give up this habit far more than others want you to give it up.

Some Had Rather Die

Some persons would rather die than give up drinking and that is just what some of them do in time. Alcoholism is the third largest public health problem in America today. Thousands die each year rather than face what they might uncover or discover about themselves if they sobered up long enough to evaluate life.

There are many who will try to explain that the reason you have not stopped drinking is the fact that you have not yet hit bottom. The AA's speak of high bottom and low bottom drinkers, meaning, of course, that some stop early, some stop late. Generally speaking, it means that there is a level of suffering which

THE MOST IMPORTANT DAY

THE psychologist William Moulton Marston asked 3,000 persons "What have you to live for?"

He was shocked to find that 94 per cent were simply enduring the present while they waited for the future; waited for "something" to happen; waited for children to grow up and leave home; waited for next year; waited for another time to take a long-dreamed-about trip; waited for someone to die; waited for tomorrow without realizing that all anyone ever has is today because yesterday is gone and tomorrow never comes.

—Douglas, Lurton, *The Power of Positive Living*

Yesterday is a cancelled check; tomorrow is a promissory note; today is ready cash. Spend it wisely.—*Typo Graphic*

Today is the tomorrow you worried about yesterday.

Reflect upon your present blessings, of which every man has many, not on your past misfortunes, of which all men have some.

—Charles Dickens

One today is worth two tomorrows.—Benjamin Franklin

the alcoholic reaches because of his drinking which becomes unbearable to him despite other rewards provided by the use of alcohol.

Yet many persons have turned back before reaching bottom, although it is equally true that many reach bottom and never turn back. Therefore hitting bottom is not the prerequisite for sobriety nor the assurance of recovery.

Recovery is based on hope. People do recover. There are over 130,000 members of Alcoholics Anonymous who are living witnesses to the hope of recovery. So let's consider this hope of getting well, for alcoholism is a sickness, but not an incurable one.

The first paradox in trying to tell you how you can help yourself is to tell you that you must seek outside help. An alcoholic is one who reacts to alcohol in a way that is different from other persons whom we shall simply classify as non-alcoholics. The alcoholic drinks more than others. More often, more in quantity, and for more days in a row than he intended. In fact the man who can choose to drink or not to drink, and actually chooses not to drink, is not an alcoholic. An alcoholic can take it or leave it, but he always takes it. The distinguishing characteristic of the alcoholic is that he cannot stop drinking, once he has begun. Or as one person telling his own story described his basic problem, "I could always stop drinking, but I could not stop starting again."

Who Initiates Action

If you seek help in overcoming your drinking pattern you have initiated the action. No one has then forced it upon you. In my ministry I have dealt with scores of alcoholics. In some cases I have succeeded miraculously; often I have failed miserably.

But this fact I do know for certain: Whenever I find a person who tells me he is going to stop drinking on his own, by his own means, and without the help of AA, rehabilitation plans or what have you, I know at that moment one inevitable cer-

"I'm not an alcoholic, y' understand.
My trouble is I just can't quit drinking."

tainty! That person will get drunk again.

I do not know the odds, but certainly it must be about 99 to 1 against self-help that eliminates allowing others to help you. In fact when I have asked persons to let me call in AA, send them to a Mental Health Clinic, or to a planned rehabilitation program in a hospital and they reject any suggested plan, it is in reality telling me to keep my nose out of their business. All I can do is back away and hope.

Eternally Committed

When this happens between patient and a medical doctor discussing an organic disease, the doctor can easily say, "unless you accept my advice and follow prescribed treatment, I will withdraw from this case and not be responsible for your life." But the minister remains eternally committed to his patients. He is under Holy Orders to serve his flock, despite their rejection. This may result in culturing his own brand of ulcers, but in conscience he just can't let go.

There are many types of help which you can use. First of all there is medical help. If you have been drinking a long time your body has taken a terrific beating. Alcohol is not a poison and it does not injure your body. It is a deficient food which gives you energy to keep going, but it allows your body to become depleted by exhausting the vitamin deposits, decreases resistance to disease, and in general subject to severe malnutrition. So you may need medical help before moving into other areas of assistance.

There is also a specialized form of medical help which is called psychiatry. You are probably convinced at this point in your life that your wife (or husband) needs the psychiatric help. In this you are right. She (or he) is as much a part of the problem as you are. The neurotic needs of the spouse are always involved, and it would be of real value for the spouse to receive outside help. Why not suggest that both of you seek outside help since both of you need it.

AA Movement

The best practical help in America today in finding sobriety is the Alcoholics Anonymous movement, commonly called AA. I remember one evening standing in a little circle with a psychiatrist and a medical doctor who worked well with alcoholics. We were discussing our community problem in helping alcoholics and the psychiatrist said to the two of us: We've just got to admit that the AA's have succeeded where the psychiatrist, the doctors and the

THE ADOLESCENT'S DRINKING PROBLEM

IF drinking threatens to become a problem (for adolescents), the concern of parents should be to discover why a young person needs the transient sense of well-being and the false sense of importance that alcohol lends. The resort to alcohol may betray a sense of insecurity and inadequacy that needs to be brought to light and sympathetically treated. Anyone whose inhibitions are such that he must try to get rid of them to feel happy needs help. Such help can come only from people whose training has fitted them to unravel the causes of the fears and doubts the person has about himself that make him need bolstering up.

—Marion L. Faegre in *The Adolescent in Your Family*

Church have failed.

The pastor may be of inestimable value if used properly, and if he has some real knowledge of the problem. Yet all he knows will be of little value to you unless you go to him for help. The doctor can't wish your appendix out, and there is nothing I can do to help unless you really want me to.

Requirements For Recovery

Quite naturally there are certain requirements for recovery. First of all you must have good care. I know that when members of your family are ill they get the best. Surely in this matter you don't want less than the best. This may mean taking time off from your work to get well. Every community today has good medical facilities. Most towns of any size have AA groups, and psychiatric help can be arranged through any doctor's office.

The second requirement for recovery is that you must have a goal in sobriety to allow you to find compensations in sobriety which will be greater than the compensations you find in your drinking. You drink because at the moment you are certain that the immediate reward is greater than sobriety could bring. However, the recognition of the rewards of sobriety may mean a genuine inner change that allows you to reevaluate the desirable characteristics of life.

I had the good fortune to hear Dr. Harry M. Tiebout, psychiatrist, give his now famous lecture, "Surrender versus Compliance in Therapy," with special reference to alcoholism. He pointed out vividly the need to distinguish between submission and surrender. In submission the person agrees consciously but not unconsciously. The alcoholic promises wife, husband or parent that there will be no more drinking and states that the lesson has been learned, but lurking in the unconscious there is the feeling and knowledge, "There'll come a time I can drink and they won't know it." In submission and compliance with external pressure there is always inner tension, a dog-in-the-manger type of sobriety. Surrender cannot be forced, or brought about with logic, for it is a thing of the spirit. But surrender can be measured by the removal of tension and inner conflict which the person then possesses. Thousands of AA members testify of this release from turmoil that comes when they admitted they were alcoholics and turned to God and others for help.

Sobriety Is Turning Point

Perhaps the next point to present here is that although the goal of the alcoholic is sobriety we cannot lay too much stress on sobriety. Sobriety is the turning point, the means by which other things can be achieved now that the mind and energy can be released to other channels. The 12 Steps of AA include a statement that the person is entirely ready to remove all defects of character.

There is a period following the achievement of sobriety which is commonly referred to as the "dry drunk." The alcoholic is at this stage far more irritable, unreasonable and jumpy than when he is drinking.

It is when a man gets as tight as a drum that he makes the most noise.

You can't keep both yourself and your business in a liquid condition.

Walking into a bar optimistically and coming out misty-optically accentuates the inevitable.

Cocktail: an ice cube with an alcohol rub.

Convalescence in alcoholism is much more painful than the disease itself. But beyond this stage when prolonged sobriety has been achieved there are at least three other important factors to be sought.

One is the achievement of self confidence. No one can trust others who does not first trust self. We are not dealing at this point with logic, we are dealing with Faith. The essence of difference here in achieving self confidence and of being able to help one's self, is that Faith includes God and self improvement doesn't. Self confidence means letting God do His share of the work, which means it will get done. The universal experience of all AA members is that they found the ability to achieve sobriety after turning their lives over to God, having found their own efforts produced unmanageable lives.

The second quality beyond sobriety is what, for lack of a better word, we might term integrity. It is more than morality. It implies being honest to self as well as to others.

The third area is productivity. That is why the AA member is a missionary. He must carry the message of sobriety to others and practice the principles in all his affairs.

Love Is Essential Factor

Perhaps the essential factor we are dealing with in sobriety is the matter of finding the ability to love and be loved. One of the characteristics of the alcoholic is the inability to love and to be loved. Unfortunately, many think the difficulty here lies in the fact that the alcoholic loves self too much to love others, but this is precisely what he cannot and does not do. The alcoholic cannot love his neighbor because he cannot love or accept himself. Here again we must enter the real realm of religion and accept the fact that no matter what has happened in the past, love must be accepted and returned, if the human heart is to be healed.

Yet accepting or giving love means willingness to accept help. It may mean a complete change in life or it may mean little change. For some persons sobriety and accepting love change little of the routine of life but transforms a life of conflict and tension to one of love and affection. For others it may mean a complete revolution. And we must not forget that sobriety and growth on the part of the alcoholic must mean growth and change in attitude on the part of your spouse or parent. To preserve your best chance of sobriety you must play this game as a team member. Once you attain sobriety and begin working with others in the spirit of love the entire family will be more inclined to let you quarterback the team than it did during the days you ran the family, but not as a team.

Right here I'll make you a little wager! You will find that you will be much happier with prolonged sobriety than you were when you drank intensively. But don't look for this happiness overnight. It took you some little time to get the alcoholic pattern really working, and it may take some time to get it ironed out. So don't be discouraged. I remember hearing one old time AA member tell a new group that he deteriorated spiritually, morally and physically and that he had to come back in reverse order. His body healed first, his moral life and attitudes next, but that it took him three years to feel he could set foot inside a church again. So don't feel you've got to make it in 30 days or 90. If you slip, just mark it down to experience and start again. The ones who make it the first time may have just a taint of intolerance toward those who don't. I don't advise a first slip, but if it occurs, use it for experience, not

defeat. Let it say to you, "I just can't use the stuff."

In regard to how you can help yourself by becoming a member of AA, it is not something you join as you would by going to a hospital. Membership in that organization should never be sought to please your family, the boss or any other outside member. Right here we have an excellent illustration as to what you can do to help yourself. One friend of mine in AA joined for wife and family. He worked at it but occasionally fell off. During his long periods of sobriety he was a wonderful missionary. Finally the old pattern came back and his status was that of a drinker again. He really worked at it but somehow he never made the grade. Finally he realized he was doing all this for others, to please his family, to get his wife back. In one awful moment of insight he realized he had never gone to AA for his own sake. The last time I saw him he was radiantly happy. "My wife and child are back with me," he said. "It's a funny thing. As long as I tried to stay sober for them I never made it. When I finally realized I wanted to

PRINCIPLES FOR THE CLERGY IN THE PASTORAL CARE OF ALCOHOLICS

1. As clergymen we are concerned with alcoholics and their families as people suffering from a major destructive force of family life.

2. A typical ordained priest, minister or rabbi as a man of God contributes toward the restoration of the alcoholic, his family and the society in which he lives by making available to them the grace, love and concern of Almighty God and the fellowship of the church community. It is recognized that there is a special group of clergymen trained specifically for counseling those presenting behavior problems and disorders.

3. The clergyman's primary job is to be a minister. He does not need to play the role of physician, psychiatrist, social worker, or rehabilitated alcoholic. The Church has a vital part to play as a Church.

4. The clergyman can contribute much as a member of the rehabilitation "team" by providing the essential spiritual component, counseling and accepting the family, helping the community to accept the alcoholic as a sick person, and when he returns to church to accept him as any child of God.

5. Church leaders—both ordained and laity—must not be ecclesiastical isolationists, but should above all exchange information and use of the modern religious and scientific insights and resources which are now available.

6. Specific techniques for preventive education were demonstrated at the Institute because prevention through education is a major task of the Church.

7. The Institute emphasized the great need for training in the schools of theology to prepare future clergymen more effectively to help these sick people and their families.

8. Religious education generally for all ages regarding alcoholism must be oriented toward shaping and building of Christ-like characters.

Further theological studies and discussion based upon these principles are of utmost importance.

—adopted by the Ministers Seminar, Yale Summer School of Alcohol Studies, 1955.

get sober for myself, that was the real turning point."

If you cannot find your way in AA all chance for recovery is not lost. I recommend it above all else as the best means of maintaining sobriety. Yet it does not appeal to all persons. If you give it a real try it will work. But if it is not a go at AA for you, then try psychiatry, counseling, medical help, etc., but remember the change from drinking to sobriety occurs within you, not in the externals of life.

Back To Church

Another practical suggestion. Go back to church as soon as possible. The Episcopal Church has one tremendous advantage in dealing with alcoholics. The best way I can explain this is to relate the following incident: In a diocesan committee meeting I was asked to explain the AA movement. While describing it as a spiritual movement quite like the early church, believing in the power of God to change human lives and founded upon the action of the Grace of God, I was interrupted by a fellow clergyman. The man has an earned Doctorate, originally taught in the University, but in recent years left his former church and teaching profession to become an Episcopal minister. He said, "Pardon my interruption but I can't help butting in to say that what has just been said about AA is the very reason why I came into the Episcopal Church. I got tired of belonging to a church which kept telling people what they ought to do and at the same time found that the Book of Common Prayer and the Episcopal Church held out to men the Love of God, the Grace of God and the means of changing their lives."

The services of your church relate to your condition. We meet as sinners seeking forgiveness. We come to church to be cleansed and to be restored. Many of our sins are far worse than your drinking. I am profoundly aware of the fact that my sins of omission may be the one thing that has not allowed you to discover sobriety, for as your minister I should at least try to help you find it. This letter is part of that attempt.

Yet we are dealing with a paradox. I have been trying to tell you how you can help yourself, and yet to help yourself you must allow God and others to help you. The door out of the dark room of despair of alcoholism opens inward. You can't force your way through it the wrong way. The first step to recovery is opening the door and letting others help.

Remember too, that God stands outside that door. He never forces his way into your life. He allows all of us to be rebellious and to choose not to turn to Him, not only in this world but forever. God gives to every person the right of utter rejection.

Privilege Of Rejecting

I must also let you know that I must give you the same privilege of rejecting my offer to help. We have no right to break down that door and invade the privacy of your life. We have to stay out until you open the door and let us in.

We are at this point right back where we started this letter. The real choice in finding and maintaining sobriety is allowing God and others to help you.

Sincerely,

Your Rector

Humility is an emotion caused by suddenly shrinking to one's normal proportions.

Mothers, Wives, and Alcoholics

(Continued from page 11)

to myself, but if I project it to my wife, saying that she is unfaithful to me, my position will change. I will change to the high moral plane and my wife will come down. In that way we may become closer to each other. Our incompatibility is an established fact, but I have converted all the responsibilities by convincing myself that my promiscuity is non-existent; by projection I have placed all the blame on her."

Some people think that alcoholism is a circumscribed entity, a self-perpetuating process that can hit anybody. Maybe it can; maybe it can't. But we know this much: these signs indicate certain weaknesses in the emotional structure of the individual. We also know that the more he drinks the more trouble he gets into and it usually happens on account of these same things. It will become a self-perpetuating thing. The more he drinks the less will be his sexual power. Prolonged alcoholism usually brings about an early climacteric in the male as well as in the female. The interest of both for sexual contact evaporates.

We can see what any man, not only the alcoholic, can do with difficulties originating from the oral and genital conflicts, and we also can see the large number of features that he can use for compensating.

Many alcoholics, for example, quit school at an early age. They quit because "I had to help Mother." The compensatory attitude is this: "I will work, assert myself, make myself important, acceptable; and also subconsciously I will expiate the possibility of aggression that I have against my mother. I am working to keep up the family. If I have difficulties as far as my masculine identification goes, I will try to do something about it, not only through promiscuity, but also through my external appearance. I will choose the most shining and the most glamorous type of he-mannishness. I will be a stunt man; go into show business; join the Marine Corps; anything that indicates that I am not a sissy."

The "Mother" Type

I don't have to say what type and how much of a difficulty one will find in the marriage of an alcoholic. I have heard one scientist say, "What do you expect from a woman going through hell for 12 or 15 years with such a man? Would she not be entitled to be neurotic and compensated?" I think this is all true, but I don't believe that it is the whole truth, and the more I examine this question the more I find this so: In an overwhelming number of alcoholic marriages (again, not every alcoholic marriage) the personality of the wife is preponderantly the "mother" type. It is understandable how the fellow who has had some sort of trouble with mother will go through a rather stormy phase of adolescent difficulties, and then he will try to settle down with a "mother."

Many times the wives are older, which is again some sort of an indication of the "mother" in them. The personality of the wife of the alcoholic in some respects seems to be out of line just as much as the alco-

Youngster (at night): "Daddy, I want a drink."

Daddy: "Aw, go to sleep. I've wanted one for two years."

holic. If we say that the alcoholic is off the beam to the left, I think we are entitled to say that the wife of the alcoholic is also off the beam to the right. This is, by the way, how they met and how they matched.

The man who is inwardly an inadequately masculine person marries an inadequately feminine person, one who is feminine in only one way, the motherly way. To be the motherly type is probably her own defense against her inadequate femininity. These two get together and try to live in a marriage. What happens? There will be a growing discord. The man will resent anything which does not satisfy his need for masculinity and the woman will resent any action which might violate her concept of a "motherly" relationship with her husband, and slowly they start drifting apart.

Often Marries Another

Interestingly, one will find that the mate of the alcoholic not infrequently divorces one fellow on account of his drinking and then marries another alcoholic, knowing that the second husband is an alcoholic. I have in my records a case where a woman of this type has married five alcoholics, one after the other. Two or three similar marriages is not a rarity. Again, perhaps they remarry the first alcoholic husband. They say it happened on account of the children, but I am just a little bit doubtful whether it really happens for that reason.

I have described some aspects of the question of the psychodynamics of alcoholism, but again I say that I do not believe that this is the whole picture. I am not sure whether it is really entirely true, but I hope that it is a part of the truth that the marital conflict of an alcoholic originates in his psychodynamic structure as well as in the psychodynamic structure of his wife.

New Hampshire's Division on Alcoholism

(Continued from page 14)

made to establish a "therapeutic community," a new community spirit, so much so that our hospital with inpatients, outpatients, AA members, and staff interacting in an extremely close relationship has been called a "country club" by some. Nevertheless, it is our firm belief that this "community" has helped many alcoholics on the road to sobriety.

Close relations with Alcoholics Anonymous have long been established, the various groups running Saturday night meetings in our facility with the individual members being allowed to visit at any time until 10:00 in the evening. This results in a very large percentage of our patients either joining or rejoining Alcoholics Anonymous.

Educational efforts have been exerted at various levels, ranging from radio broadcasts to individual interviews. Typical of the Division's activities were those of the past fiscal year, July 1, 1954-June 30, 1955. During that time 40 speaking engagements and 5 radio broadcasts were conducted, 69 showings of movies and film strips took place and about 22,000 pieces of literature were distributed. Special conferences were held. The most widely known of these being the annual North Conway Seminars on Alcoholism for Clergy-

When you have saved a boy from the possibility of making a mistake, you have also prevented him from developing initiative.

men, the last co-sponsored by Roman Catholic Bishop Matthew F. Brady of Manchester, New Hampshire, the New Hampshire Council of Churches and Religious Education, and the Division on Alcoholism. During that two-day seminar about 200 clergymen and interested laymen attended from 13 different states. The influence of these seminars cannot be underestimated. Since the first was held in 1951 many similar undertakings have occurred in other states, all patterned after the North Conway formula.

Particularly important at this point is the development of an understanding, objective, non-moralistic attitude about alcoholism. The interest and excellent coverage of the newspapers, radio and television stations in New Hampshire have had an important role in bringing about this understanding. As a consequence of their publicizing the problem and the Division and its activities, health education has been furthered in New Hampshire.

Another important educational adjunct is the Division's regular publication, "The Bulletin on Alcoholism," which is available on request from our office.

While it is recognized that popular attitudes, if well defined, are almost impossible to change in short periods of time, it has been our experience that many people are receptive to new ideas on the subject in question. Thus we believe that the concept of alcoholism as a medical—social—religious problem which is amenable to treatment is growing steadily as a direct result of the activity of the Division and other interested organizations. It is our hypothesis that the ground work for prevention is now well beyond the experimental stage in New Hampshire.

"Oh, dear, did I put too much brandy in the fruit cake, Mr. Bourney?"

Priorities Established

With the opening of the Division in 1947 the following priorities were established for expenditure of funds: (1) treatment, (2) education, and (3) research. Although 8 years have passed since then no change has taken place in the original priority nor is any contemplated. As long as pleas for help continue to pour in, our policy is to give this help in line with the size of the staff, available funds and facilities.

With this philosophy dominant it is to be expected that research has not received its proper stress, and this is so. This does not mean that the importance of research is underestimated but that with limited funds and a pressing demand for immediate services, only small amounts of time, effort and money have been available for this purpose.

Among projects carried on or sponsored by the Division, have been a

state-wide survey of incidence, facilities, and interest of professional groups; a study of the N. H. "Jail Drunk"; a study of the efficiency of court-commitments to the Division, an examination of Chlorpromazine, and sociological surveys of the patient population.

Community Programs

Today, an ever-increasing emphasis is being placed on community organization. Our legislation permits and encourages such activity. Since the summer of 1954 a number of developments have occurred in this particular field. The first was in the small New Hampshire City of Laconia in 1954 when a number of interested citizens concerned with the problem of alcoholism met with the executive director of the N. H. Division on Alcoholism. As a result of this meeting the Laconia Committee on Alcoholism was conceived, being officially activated in October of 1954 at an open meeting attended by more than 40 Laconia residents. Since that time the Laconia Committee has engaged in educational work in the Laconia area, held a public meeting at which 150 people attended, joined the National Committee on Alcoholism, sent one of their members to the Yale Summer School of Alcohol Studies, referred a number of patients to the New Hampshire Division on Alcoholism, and helped double the size of the Laconia AA group.

A similar committee is now being organized in the City of Nashua, New Hampshire.

A somewhat differently oriented and structured type of organization evolved in the Fall of 1954 from the clergy seminars held in North Conway, N. H. This was the North Conway Foundation, an interdenominational group, dedicated to bringing about enlightened church participation in the field of alcoholism. The Reverend David A. Works of North Conway is spearheading this organization, the only one of its kind in the country.

With the exception of very small federal appropriations during the fiscal years 1951, 1952, and 1953, the Division has always received its funds from the general appropriation of the State. Although the possibility of earmarking funds from the sale of alcoholic beverages or registration fees is periodically discussed each biennium, no change has ever taken place.

Beginning with an initial appropriation of $15,000 for the fiscal year 1948 and including the fiscal year 1957 with its $80,000 gross appropriation, the Division has received a 10-year total of slightly under $500,000 or an average of about $50,000 per year.

Future Plans

For the future we have plans for all 4 levels of activity:

(1) in the treatment area we intend to integrate our "Therapeutic Community" more carefully into our total treatment picture, to expand our group, occupational and recreational therapy programs, and to establish new rotating outpatient clinics in other areas of the state.

(2) For education we plan an expanded program in a number of areas. The circulation of our "Bulletin on Alcoholism" is increasing steadily, a special training program for Public Health Nurses in conjunction with the State Bureau of Public Health Nursing and the U.S. Public Health Service is in the formative stage; workshops to aid public school teachers in their use of a new teachers' guide on alcohol are being considered, and an industrial training program in conjunction with the N. H. Manufacturers Association is in the discussion stage. These are

perhaps the major new or extended educational objectives.

(3) For research we plan a careful examination of detailed statistics of our patient population for the last two years. A brief scanning of the data leads us to believe that new and important hypotheses can be developed in addition to substantiation of other findings. Consideration is also being given to publication of the various treatment techniques which we have developed with illustrative case histories.

(4) In the community organization sphere we plan to assist the Laconia Committee in its expansion, to help the Nashua Federation of Social Agencies in its development of a committee on alcoholism and to continue our cooperation with the North Conway Foundation on Alcoholism.

These activities represent our attempts to meet our legislative obligations of treatment, education, research and community organization.

The Editor's Page

(Continued from page 6)

reprints become available announcements will be made in *Inventory*.

No changes are anticipated in our free distribution policy. *Inventory* will continue to be sent without charge to all persons who send us a signed request. It will not be sent to persons other than those who personally request that their names be added to the mailing list. All other publications are free in reasonable quantities on request of North Carolina citizens. People from other states and countries who request these materials will be sent one free sample copy of each requested publication. Should these out-of-staters desire materials in quantity we will be glad to send a price list.

The Road To Sobriety

(Continued from page 8)

often by their stolid, dogged tempo to life in general. That is the secret of their contrasting apparent safety "in their cups," and the disastrously dangerous drinking of alcoholics. Even though the whole riddle of years of compulsive, selfish drinking may now stand revealed in all its ghastly truth to an alcoholic, yet he must remain forever and irrevocably linked to the disease! Indeed, it is the full recognition and acceptance of this fact which initially sets him on the road of recovery. Not until then can his path be cleared for a new adjustment to life. The living of this life is made possible only by a spiritual awakening combined with expert instruction about alcohol and its effects on alcoholics.

To an alcoholic, it is the first drink which leads to trouble. To him one drink is too many, and a score not enough! Without his knowledge of this, he cannot be on his guard against taking that first, fatal glass. He is a victim of his own disease: he WANTS to stop drinking after every heartrending episode, but does not know how. He is in a vicious circle of self-damnation. Alone, he

The world is not interested in the storms you encountered, but did you bring in the ship?

—William McFee in *Tales of Hoffman*

can never escape. Nowadays, however, with the aid of enlightened societies specializing in this treatment, the prognosis of recovery is excellent.

A recovered alcoholic wrote to me the other day a long letter. It inspired the writing of this article. Five years ago he had sold his home to get more whiskey. He was put in touch with people who knew how to help him, and they found him to be a very tough case. However, a year later he "took the plunge," stopped drinking, accepted the new outlook on life offered him, and started to rebuild his home and homelife. Today, he has his home back, his wife and children have returned to him, and he is active in helping others in the same plight that he was in. He has not tasted alcohol for four years. It is extremely unlikely that he ever will again; not voluntarily at any rate. I have his permission to quote a short part of his letter here:

Two Personalities

"They said that I was sensitive, intelligent and kindness itself in my sober periods. Alas, how vile I was when drinking! At times, I aspired to be almost any other character than that which I was. I had nerves that tingled and tensed at the first rebuff I received, real or imagined. Another excuse for a drink, you see!

"It matters not how long or not-so-long I have been 'dry.' A day at a time is all that counts to me now. Yesterday is gone, but tomorrow may not arrive should I fail to remember what that single, first drink can do to me! Today, I expect all the inconveniences, disappointments, annoyances, and frustrations that are the general lot of non-alcoholics too. But I have a remedy now. I cannot afford NOT to be on top of my troubles, lest I become too prone to that tickling relish on tongue and throat, that strung-up nerve sensation, and that racing, aching brain—all, all disposing me slowly towards than ever fatal first glass. I can neither crush these powerful sensations, nor will myself not to respond to them.

Finding Other Outlets

"What I can and do do, if I am to be imperiled no further when in these throes of the dreadful craving for alcohol, is to divert the energy so set up by one of a number of outlets. A brisk walk, or an hour doing the garden can help, combined with large quantities of soft drinks. Again, I can ring an understanding companion for a chat about things. If he is like me, he will be delighted to hear from me. Failing that, I can take up pen and paper and write, even though the tears come trickling down my cheeks, to some person who is also an alcoholic, and would appreciate a letter. At any rate, I can write down my thoughts to him without fear of being ridiculed! And behold, the trick is done; the sensations towards drink weaken, then subside altogether. My tension is gone. The tickling tongue and throat and jumpy stomach are consoled by generous gulps of GLUCODIN in milk, tea or fruit juice. With that, I can really enjoy my pipe which, had I taken that other drink, would only have been stuck in my mouth insipidly. I have remained sober another day, all thanks to knowledge of alcoholism, and those who troubled to instruct and help me.

"Not today shall I be an object of compassion to my relatives and friends, nor of derision to my not-so-friendly ones. Not today shall I be stared at by fools, nor suspected by strangers. Instead, today I shall be sober. Yes, just for today, a day at a time. No exterior force can compel me to be otherwise. Nor yet can the

admitted force of the alcoholic's sensations within me, now that I KNOW what to do at the time, drive me to take that drink which counts me OUT! That drink which is one too many: the first drink!

"Gone are the appeals of my protesting friends of my drinking days. The hideous nightmares are over too. Dried are the scalding tears of my wife, and children, and my mother also. Their features bear a new radiance nowadays. The reprobating world I have floundered in wears a new look of respect for me! What matters it now, if during my first evening or week, or even month of abstention I screamed out from the alcoholic strife within me? Is not this new-found sobriety a Golden Achievement beyond price, and further than the wildest hopes of my vain attempts previously to 'go on the wagon'?

No Middle Way

"ACCEPTANCE of life without alcohol; ADJUSTMENT to that life; ACHIEVEMENT of continued sobriety. This is serenity enough for me. Never again shall I look at that heinous mirage, the middle way between total abstinence and the excess that imperils me. I am sticking to the Oasis of Safety in doing without drink for a day at a time. It never fails me."

Yes, the dissemination of knowledge about the disease and its treatment, combined with the setting up of community resources for the handling of accepted cases, is doing the trick: solving the problems of these "problem drinkers" who have long baffled the united attempts of the social experts.

It's My Opinion

(Continued from page 15)

whole thing. For the recovered alcoholic, life becomes far more vital, and full, and worthwhile, because he can always compare it with the depths of despair which he has known. For the man or woman who wants to do something about their problem, AA stands ready and willing to help without asking a question. The only requirement is a willingness to try—and the way is simply by attending meetings. They're everywhere if you want them.

Dick C.
Robesonia, Pa.

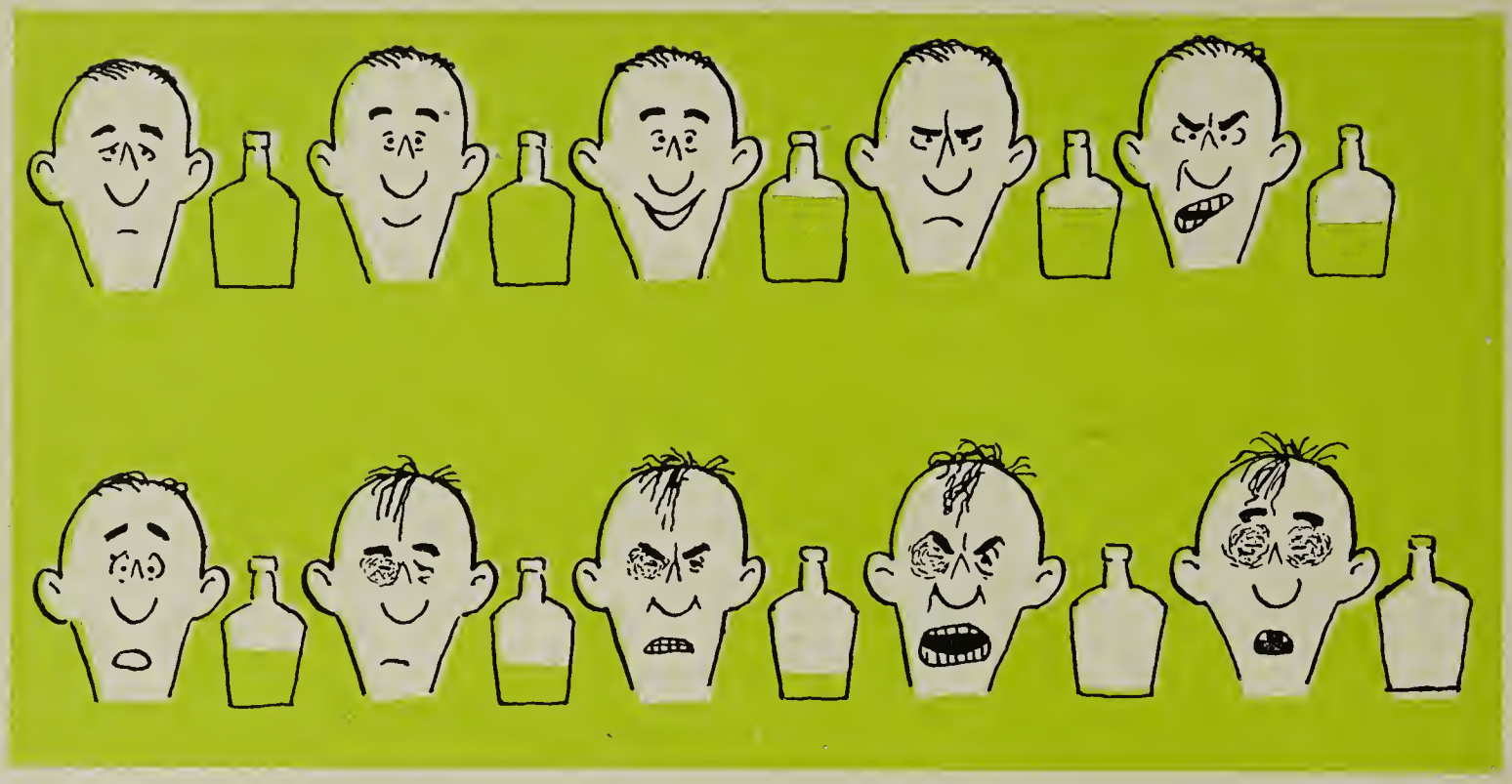
Program Pointers

(Continued from page 3)

ing toward their ultimate objectives. The Committee hopes ultimately to obtain funds for the support of a full scale community alcoholism program similar to the one now in operation in Winston-Salem.

There is a great need for more community alcoholism programs in this state to provide treatment, education, and prevention services at the local level. Naturally, we of the ARP are eager to see such a program established in Asheville. I am confident that through the continued efforts of the Asheville Citizens Committee that dream will be realized. We are happy to have had some part in their work, and we assure them of our continued support and good wishes.

We cannot be happy until we can love ourselves without egotism and our friends without tyranny.—Cyril Connolly



FOR WOULD-BE WRITERS—

A DO-IT-YOURSELF STORY KIT

WE'RE being facetious, of course, but with a purpose. It takes more than an idea to write a story, but at least it's a start. And that's just what we, your editors, hope you will do—start writing stories for *Inventory* that will in some way contribute to the public's understanding of alcoholism.

Many of you are members of Alcoholics Anonymous. Your personal stories would be interesting and informative, not only to other AA's, but to the other thousands of people in all walks of life who read this magazine. Call it Twelfth Step work if you will and help us to enlighten the general public through your own experiences and understanding.

There are educators among you, and psychiatrists, psychologists, general practitioners, pastors, pastoral counselors, social workers, judges and law enforcement officers. You too can contribute considerably to the public knowledge about alcoholics by writing us about your research or experiences with them. We would also like to publish articles by the wives, mothers and children of recovered or unrecovered alcoholics.

We don't ask that your articles be of "professional" quality. Just tell us in your own words what you want to say. We may be able to help clarify your thoughts for our readers in editing the article. Neither will it be necessary for you to have the article typed. Write it in pencil on a grocery sack if that's all the paper you have. The important thing is: write it. Try to write not more than 1,300 words (the average length of articles in *Inventory*). If you can tell the story in 500 words that's all right with us.

We won't be able to pay you for your work, and we cannot guarantee that we will publish what you write, but we will acknowledge every manuscript we receive and should we be able to publish it in *Inventory* we will send you ten or more copies of the issue in which it appears.

We know that's a mighty poor offer for your time and effort, but if you help us to publish articles of interest, *Inventory* may be instrumental in helping someone you know to live a sober, happy and productive life — not because that person may read it, but because you have helped to enlighten someone in the general public or the professions from whom he may need help sooner or later.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
210 N. Greene St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
CHAPEL HILL, N. C.
Phone: 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

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JAN.-FEB., 1956

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

The Fellowship of Alcoholics Anonymous

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

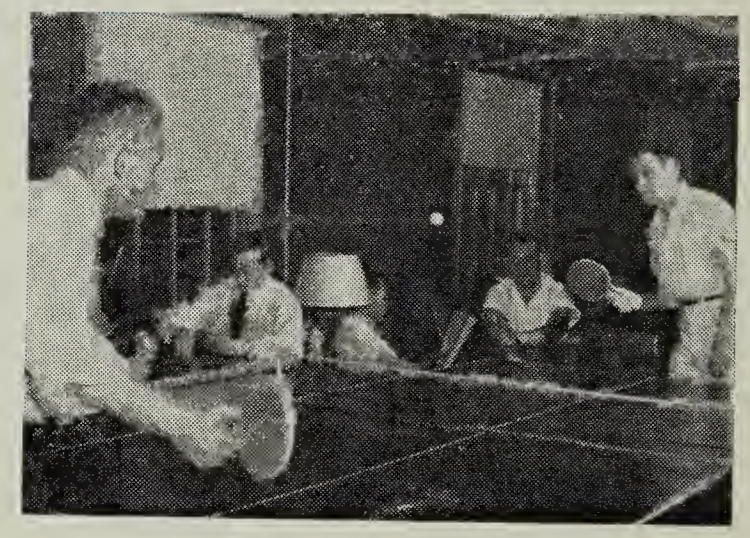
Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, and occupational therapist, and ten attendants.

The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.
2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.
4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center has a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 11 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM
OF THE
NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

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Clinical Director

INVENTORY

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RALEIGH, N. C.

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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

SYMPTOMS AFTER WITHDRAWAL

CANADA. Writing in the Journal of the Canadian Medical Association, M. Wellman describes the later withdrawal symptoms as they occur in some alcoholics who give up drinking. He reports that the symptoms are most severe the first 6 months of abstinence, diminish in intensity and frequency in the following months but may occur as late as after 5 or 10 years of abstinence. The syndrome consists of irritability, depression, insomnia, fatigue, restlessness and a "sense of aloneness and distractibility." Physical signs include a red face, heavy perspiration, elevated pulse and lowered blood pressure. There is also confusion and occasionally anxiety.

HIGH, TIGHT, AND DRUNK DEFINED

NEW HAVEN, CONN. Confusion is general regarding definitions of the words: High, Tight, and Drunk. In their book, "Drinking In College," Robert Straus and Selden D. Bacon offer the following definitions: "**High** would indicate a noticeable effect without going beyond socially acceptable behavior, e.g., increased gayness, a slight fuzziness of perception, drowsiness and the like. **Tight** would suggest an overstepping of social expectancies, or noticeable aggressiveness, or oversolicitousness, or loss of control of social amenities or of verbal accuracy, or slight nausea. **Drunk** would suggest an over-stepping of social expectancies, loss of control in ordinary physical activities, and inability to respond to the reactions of others." Now you know.

CONTROLLED DRINKING AND METABOLISM

TORONTO. R. B. Bell, in a report to the University of Toronto Medical Journal, suggests that controlled heavy drinking over an unspecified period of time can result in a breakdown of metabolic equilibrium, leading to uncontrolled drinking. He describes uncontrolled drinkers as those who drank originally to allay physical pain, those whose life experiences were so painful that they needed oblivion as the only adjustment and those (the largest group) who seek reduction of tension states. He theorizes that the latter may have a carryover of adjustment problems from childhood or they may be involved in adult situations requiring daily adjustment to a great variety of stresses.

CHLORPROMAZINE PROVES PROMISING

CONNECTICUT. In a copyrighted article in the Alcoholism Treatment Digest, New Haven, a new drug for treatment of the immediate post-intoxication state is discussed. Named chlorpromazine, the drug has been studied by various doctors and used experimentally with groups of agitated alcoholic patients suffering from the after-effects of intoxication. Chlorpromazine appears to have several desirable effects. In a study conducted at the District of Columbia General Hospital with 164 newly admitted alcoholics, J. D. Schultz and his colleagues reported that the calming effect of the drug was remarkable. In all but a very few cases the patients went to sleep within 30 minutes after the drug was first injected. Sleep lasted 3 to 8 hours, but the drug did not act like a hypnotic; thus, the patients could be easily aroused. Chlorpromazine had a striking action on the digestive system, enabling patients who had been vomiting almost continuously to soon retain light foods and fluids. Additionally, the drug had a direct effect on the "shakes"—tremors, over-activity and restlessness. The patients' feeling of anxiety, however, was not always controlled by the drug. The value of the drug is reported to lie in affording easier management of the acutely ill alcoholic patient without creating nervous system depression through large doses of sedatives. It was observed also that chlorpromazine does not combine with with alcohol—as barbiturates may—to increase the depression of the nervous system. Several side effects of chlorpromazine were observed, including dizzines, dryness of the mucous membranes, weakness, faintness, flushing and palpitations. In no case, however, were the symptoms alarming. Schultz and his associates recommended that the patients should be watched closely, particularly after large doses, and kept in a recumbent position.

ANTIHISTAMINES AND ALCOHOL

GREAT BRITAIN. In the British Medical Journal a case is described wherein the combination of antihistamine capsules and alcohol landed the defendant in court for being under the influence while operating a motor vehicle. His doctor testified that he received antihistamine capsules for an allergic condition. He also partook of a moderate amount of alcohol. "Although there was no immediate effect," according to the report, "it seemed now quite certain that there was disorientation as a result of the capsules affecting the alcohol." It advised motorists to be aware of the possible effects of antihistamines in combination with alcohol.

ALCOHOLISM RATES ARE DESCRIBED

CANADA. In a statistical report relating to alcoholism in Canada, Robert E. Popham compares rates of alcoholism per 100,000 population 20 years and older for several countries. France leads with 5,200 per 100,000. He lists the U. S. next with 3,952, followed by Sweden with 2,580, Switzerland with 2,385, Denmark with 1,950, and Canada with 1,804. In terms of gallons of absolute alcohol consumed per capita 15 years and older, France leads with 2.95; U. S., 1.66; Sweden, 1.06; Switzerland, 1.60; Denmark, 1.29; and Canada, 1.48.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

PREVIOUSLY, we brought you the news that "Domino," the ARP film on alcoholism had been completed. Now we are glad to report that prints of "Domino" are beginning to circulate among the state's television stations. Raleigh's Station WNAO-TV carried "Domino" in the 7:00 to 7:30 p.m. slot Saturday, December 3. WTVD in Durham has booked it for December 31. WITN-TV, Washington will carry the film on an as yet unannounced date the latter part of the month. Other television stations in the state have indicated their willingness to schedule "Domino," and we expect that coverage will eventually include the entire state. Watch the television schedules in your area so that you won't miss "Domino." After you have seen it, write us your candid comments.

At this writing, we are saying goodbye to our friend and colleague, Dr. Lorant Forizs. As you may know, Dr. Forizs has taken over the Clinical Directorship of the Florida Alcoholic Rehabilitation Program, and is moving with his family to Avon Park, Florida. Dr. Forizs was the first Clinical Director of the NCARP, and we are grateful for the untiring interest and enthusiasm which he brought to this task. In spite of pressing duties at the Butner State Hospital, Dr. Forizs was never so busy that he couldn't find generous amounts of time to devote to his work with alcoholics at the Rehabilitation Center. I personally owe him a debt of gratitude for his skillful assistance in helping me to gain a clearer understanding of alcoholism as an illness and of the alcoholic as a patient.

Dr. Forizs spent a lot of effort in indoctrinating the professional staff of the Rehabilitation Center from the richness of his experience and thinking. Because of his efforts in this direction, he is leaving a staff fully capable of carrying on the fruitful work which he has directed since 1950. I am sure that former patients of the Center join with me and the staff of the NCARP in wishing Dr. Forizs continued success in his new position.

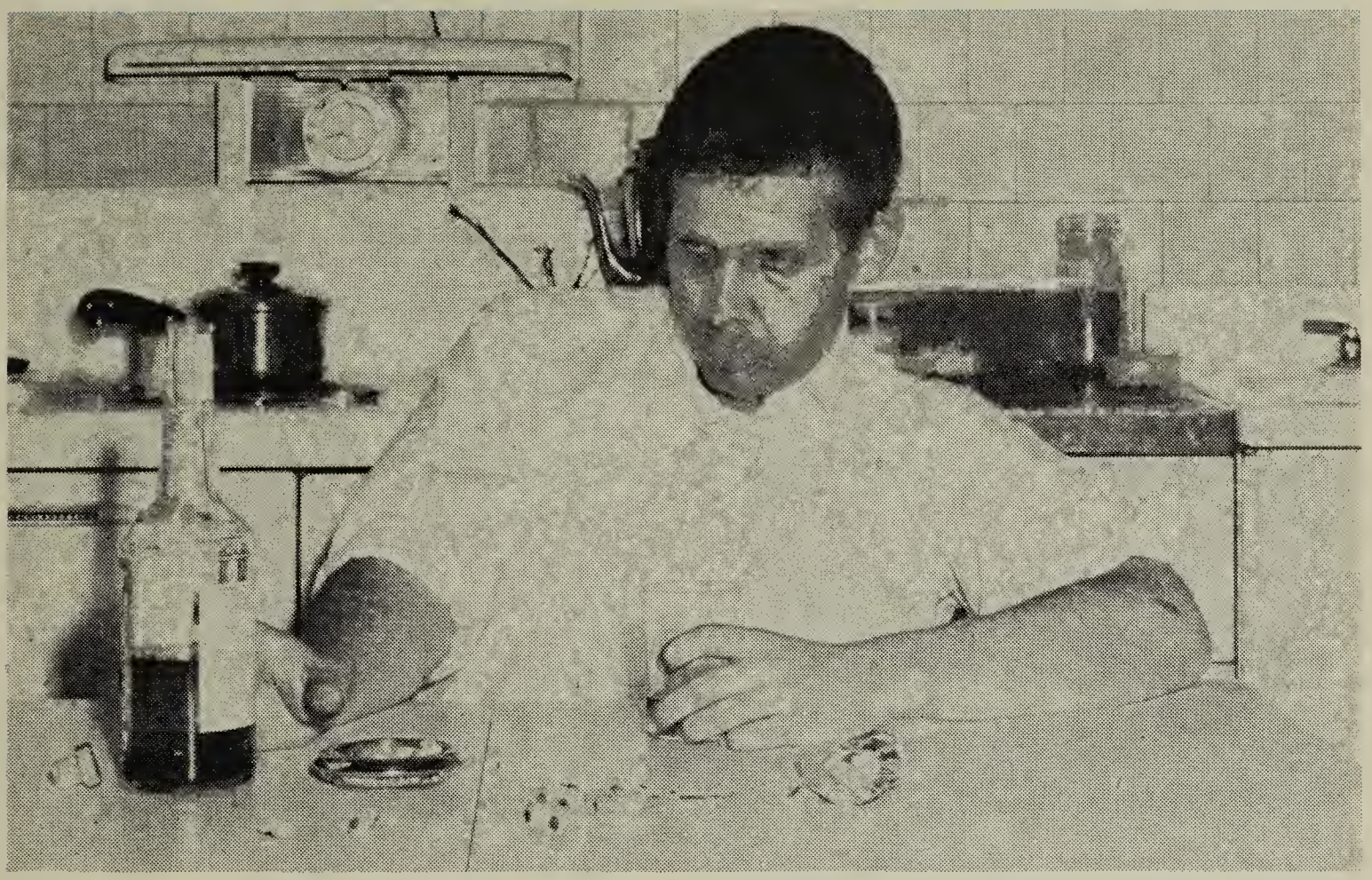
Prison Education

Our alcoholism education program for the Womens Prison is now in progress and the initial impression is encouraging. Dr. Kelly, and Miss Lytle have already held the first two in a proposed series of seven meetings within the prison confines. The first was a "get-acquainted" meeting, and was attended voluntarily by 116 women prisoners. The second meeting featured the film, "Alcohol and the Human Body", followed by an open discussion period. This time voluntary attendance swelled to 153, including both white and Negro

(Continued on page 32)

VOL. V, No. 5 **INVENTORY** JANUARY-FEBRUARY, 1956

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM



PROBLEMS ASSOCIATED WITH ALCOHOL

BY JOSEPH HIRSH

● *An educator explores the issue realistically*

MOST Americans drink alcoholic beverages. Most of them drink socially, and most of them have no difficulties and no problems in connection with their drinking.

Alcoholic excesses in some Americans on the other hand, do create or contribute to any number of problems, both for society and for the individual who is intoxicated or a victim of alcoholism. Alcoholics are responsible for disturbed and broken homes. The illnesses which are part of, or which are acquired in connection with alcoholism often cause them to be confined to hospitals. Some alcoholics become involved in crime and end up in jail. Many lose their jobs or use what money they have to keep themselves in liquor, and the state or local government must pay for the support of neglected children, hospital care, or jail internment. Traffic accidents, delinquency, divorce, are other major social tragedies to which alcoholics contribute.

It should be realized that society would be confronted with all of these

problems even if there was no alcohol.

To direct attention to possible cause-and-effect relationships between alcohol and traffic accidents, delinquency, crime and other social ills, is but a minor aspect of the educator's responsibility. Much more urgent is the need to establish firmly society's responsibility for dealing with *all* these problems—including alcoholic excesses.

In this light it is important to review some of the major social problems in which alcohol plays a role of greater—or even smaller—importance.

Alcohol And Reflexes

Traffic accidents and alcohol are definitely related. Many studies conducted by the National Safety Council and others indicate that the causes of traffic accidents are the following, in order of their frequency: driving on the wrong side of the road, proceeding without having the right of way, running off the road, and general recklessness.

We have seen that even a small amount of alcohol may have certain physical effects that would cause a driver to do precisely those things, i.e., poor judgment, loss of concentration, reduced coordination, impaired vision, hearing, and ability to gauge distance.

Similarly, studies of behavior of pedestrians injured or killed in automobile accidents, reveal that the important errors they made were in the following order of frequency: crossing against the lights, crossing in the middle of the street instead of at the corner, playing in the street, coming from behind a parked car, crossing where there were no signals, etc. Here again, inattention, indifference, recklessness, are all states of mind and body that can come about as a result of drinking.

We have seen that as little as one ounce of alcohol taken on an empty stomach without very much dilution may, in an average person, impair vision and hearing, and reduce ability to concentrate for the next few hours. Reflexes and coordination of motor activity are almost instantly affected.

Reaction Time

A typical before-and-after laboratory test of the reaction-time of drivers indicates that *before* alcohol is taken, the average time it takes to press the foot-brake after a red light is flashed, is 1/5 of a second. A short time after two glasses of beer are consumed, it takes 3/5 to one full second to accomplish this. The difference in these reaction times may mean the difference between life and death on the road, when it is considered that a car traveling, for example, at 60 miles an hour, actually moves 88 feet a second or a little more than 17 feet in 1/5 of a second.

Accidents

On the basis of a number of such tests, the National Safety Council has stated that persons with .15 per cent alcohol concentration in the blood (the point at which many states consider a person to be intoxicated or "drunk") are 55 times *more likely* to get involved in automobile accidents. But even more dangerous it has been discovered, are those who haven't quite reached that degree of intoxication, who *look* perfectly sober, and even *think* they feel "fine," but who, because of the effects of alcohol, are almost without realizing it a little less cautious and take unnecessary chances when they get behind the wheel of a car.

One out of six drivers who have been involved in fatal accidents, according to recent statistics, had been drinking. *One out of every four* adult

pedestrians killed in traffic accidents had been drinking.

Of course, other factors may have been involved in the accident, such as the physical condition of the driver or the pedestrian without regard to the alcohol in his system. He may have been physically ill, mentally disturbed, or irresponsible. His car—particularly his brakes, lights, steering equipment—may have been in bad repair, or he may not have mastered the rules of the road fully. All these are of course important to know so that adequate safety measures—standards of vehicle inspection and medical examinations—may be properly established and enforced.

Irresponsibility

It is in addition essential that *all* city and state traffic enforcement agencies (instead of the less than 200 at present), develop and use accurate physical, mental, and chemical tests to aid in identifying and prosecuting the irresponsible driver. If accident reports were more comprehensively and carefully drawn, they could and certainly should provide a most realistic basis for safety education and law enforcement.

For young people safety admonitions, such as "Driving and drinking don't mix," "When you drink, don't drive," cannot be repeated often enough. For what has been said of the effects of alcohol on the average person's ability to drive has even greater application for younger persons. Tests of teen-age reactions to alcohol have invariably indicated that much smaller quantities may have more instantly menacing effects than would be the case in an older, more experienced drinker.

An interest in driving and a desire to learn to drive is almost universal among high school students. This interest should be exploited to the utmost not alone by those who provide driving instruction, and who enforce the laws in connection with the issuance or revocation of driving licenses, but by all classroom teachers. They are in an ideal position to utilize maximally all the dramatic material available not only to demonstrate that alcohol and automobiles are immiscible, but constructively to teach concepts of social responsibility surrounding the use of a social instrument such as the automobile.

Other Accidents

In addition to automobile accidents many other kinds of accidents occur daily. The available records do not always indicate the cause of these accidents but sufficient evidence does exist to enable us to assume that alcohol is responsible for some of the 5 million accidents that occur in homes throughout the United States each year.

The National Safety Council also estimates the total cost of accidental injuries to be over a billion dollars yearly. Again, records do not always indicate the cause of these injuries, but in most factories there are high speed, powerful, complex machines, high-voltage current or explosive liquids. Any of these is a menace if the worker is absent-minded and disturbed, as would be the case if he had been drinking on the job or before going to it.

Railroad Rule

It is worth noting that in railway and air transportation where expensive equipment and the lives of passengers depend upon good judgment, drinking is forbidden. The railroad rule, which has been in effect for many decades reads: "The use of intoxicants by employees while on duty is prohibited. Their habitual use or frequenting of places where they are sold is sufficient cause for dismissal." The rule of the commercial

airlines is, "No pilot may take a drink of any alcoholic beverages within 24 hours of a scheduled flight. To violate this rule means instant dismissal."

The consumption of alcoholic beverages is unquestionably an invitation to injury, and even to death, to those who would utilize it at the same time they attempt to operate mechanical vehicles, as drivers, pilots, or engineers.

The relationship of alcohol to crime is more difficult to establish than it is in the case of traffic accidents. Many studies of crime and criminal behavior have been made to determine the extent to which drinking has been an important cause. Estimates vary. A frequently quoted figure is 60 per cent, i.e., alcohol is alleged to be the pivotal factor in upwards of 60 per cent of criminal cases. Other estimates have been as low as 16 per cent.

Twofold Significance

The difficulty confronting the statisticians in this area arises out of the fact that excessive drinking has a twofold significance in criminality. It may actually lead people to break the law, or it may merely help them to do so. Innumerable criminals have reported that "a drink or two" helps them greatly in carrying out particularly heinous crimes.

On the other hand, it is also known that most excessive drinkers do *not* commit crimes, despite their dependence upon, and frequent use of alcohol, *unless criminality is part of their personality structure.* In such instances, it would be profitable to study the exact role alcohol plays in their illness, and thereby to shed light upon the emotional crutches (of which alcohol is one) which support a criminal personality. Studies of this character are important in this field, as they are in traffic accidents, if the nature of the two diseases—criminality *and* alcoholism —is to be thoroughly understood.

The relation of alcohol to criminality can be succinctly summed up as follows: the moderate use of alcohol, while a luxury and not at all necessary either for one's physical or psychological well-being, probably does not play an important role in causing crime. The excessive use or abuse of alcohol may, however, aid and abet lawlessness.

Depressant Effect

One of the immediate effects of alcohol is the depressant effect upon the central nervous system. This in turn results in releasing inhibitions and exposing individuals to all sorts of aggressions, including sexual ones. Promiscuous behavior therefore, is much more easily indulged in, particularly among young people, and to this extent the chances of contracting venereal diseases are increased. Studies do indicate a higher incidence of infection among alcoholics than non-alcoholics, although the controlling factors appear to be other than their alcoholism, namely age, marital status, family background, church training, degree of sex education, etc.

A diagnosis of the emotional history of juvenile delinquents inevitably reveals that their problems do *not* begin with alcohol. The inadequacy of the homes from which these young people come, the indifference of their schools and communities to their physical and emotional needs, the anxiety and tension that characterize the times in which they live—these are among the *primary causes* of their delinquency. Drinking is a *symptom* of their difficulties. Like the alcoholic, the juvenile delinquent —with or without respect to his drinking history—requires treatment which combines the skills of the

medical man, the psychiatrist, the social worker, the teacher, the guidance counselor, and in some instances, the church.

In addition, of course, the availability and accessibility of alcoholic beverages to young people must be realistically controlled in the community. A combination of law and education should serve to reduce the number of young people who use alcoholic beverages regularly, and to discourage those who have not yet begun to drink from doing so, at least until such time as they have reached maturity and are able to fully assay the responsibilities attendant upon drinking.

It is estimated that about 10 per cent of all excessive drinkers eventually develop mental disorders. A number of people who are in mental hospitals for disorders that have nothing to do with alcohol sometimes are found to use alcohol in excess.

Divorces

Tens of thousands of legal separations and divorces have been granted on grounds of "habitual drunkenness," "gross and confirmed habit of intoxication," and similar charges. Again, reduction in the number of marital estrangements will come about only when attention is focused on the more fundamental difficulties which have been responsible for the recourse to, and dependence upon, alcohol.

But the effect of alcoholism on the home is perhaps as insidious, as costly, and as far-reaching as any disease with which we are presently confronted. Because alcoholic beverages are costly, homes of alcoholics are usually additionally stricken by poverty, lack of food, clothing, and other necessaries. Absenteeism and inability to hold a job are frequently a concomitant of alcoholism.

The children of alcoholics are almost always emotionally maladjusted and disturbed children, particularly where the mother is an alcoholic. By far the largest number of cases of cruelty suffered by children and adults are at the hands of alcoholics.

Female Drinking

The effects of female drinking are often more serious in relation to the home than are those of male drinking, for the mother is usually the sustaining force in the family. Unlike the father, she tends to do most of her drinking at home. Usually she is economically dependent upon her husband and as a consequence tends to buy her alcohol with the money given her to maintain the home. Furthermore, the woman's influence upon the personality and physical health of her children is a primary one and therefore the female alcoholic is in a genuine sense a "disease carrier."

The precise relationship of alcohol to broken and disturbed homes—like the many other social problems so briefly touched upon here—defy and elude statistical analysis. But the convergence of alcohol with all of these social ills is a hard reality and should be so reported to young people. For there is no more important mission before the schools today than to develop understanding of the conditions—personal, economic and social—that bring about all of these problems in the first instance.

Within recent years the inter-relationship of all problems of social disorganization have increasingly been recognized. Once educators come to accept this, then they *must* reject the teaching that places upon alcohol responsibility for all of mankind's ills. The longer the delay in discarding such teaching, the longer the delay in achieving whole-hearted and urgently needed solutions to *both* sets of problems.

HERE ARE THE ANSWERS TO YOUR QUESTIONS ABOUT

THE FELLOWSHIP OF ALCOHOLICS ANONYMOUS

The only requirement for membership is an honest desire to stop drinking. Its members share their experience, strength and hope with each other that they may lick their problem and help others recover.

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"Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problems and help others to recover from alcoholism. The only requirement for membership is an honest desire to stop drinking. A. A. has no dues or fees. It is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety."

THE "common problem" is alcoholism. The men and women who consider themselves members of A. A. are, and always will be, alcoholics. They have finally recognized that they were no longer able to handle alcohol in any form; they now abstain completely. The important thing is that they do not try to cope with the problem single-handedly. They bring the problem out into the open *with other alcoholics*. This sharing of "experience, strength and hope" seems to be the key element that makes it possible for them to live without alcohol and, in most cases, without even wanting to drink.

Another way to describe Alcoholics Anonymous is to outline the structure of the society. Numerically, A. A. consists of more than 150,000 men and women in the United States, Canada and about 40 other countries. These men and women meet in local groups which range in size from a

handful of ex-drinkers in some localities to many hundreds in larger communities.

In the populous metropolitan areas, there may be scores of neighborhood groups, each holding its own regular meetings. Many A. A. meetings are open to the public; some groups also hold "closed meetings," at which members are encouraged to discuss problems which might not be fully appreciated by non-alcoholics.

The local group, with its local meetings that permit alcoholics and their families to meet in an atmosphere of friendship and helpfulness, is the core of the A. A. fellowship. There are now more than 5,000 groups throughout the world, including some in hospitals, prisons and other institutions.

HOW DID A. A. GET STARTED?

Alcoholics Anonymous had its beginning in Akron in 1935 when a New York businessman, successfully sober for the first time in years, sought out another alcoholic and was directed to a local doctor. During his few months of newfound sobriety the New Yorker had noticed that his desire to drink was lessened when he tried to help other "drunks" to get sober. Working together, the businessman and the doctor found that their ability to stay sober seemed closely related to the amount of help and encouragement they were able to give other alcoholics.

For five years, the new movement, nameless and without any organization or descriptive literature, grew

slowly. Groups were established in Akron, New York, Cleveland and a few other centers.

In 1939, with the publication of the book, *Alcoholics Anonymous,* from which the fellowship derived its name, and as the result of the help of a number of non-alcoholic friends, the society began to attract national and international attention.

Eventually a headquarters service office was opened in New York City to handle the thousands of inquiries and requests for literature which pour in each year.

ARE THERE ANY RULES IN A. A.?

The absence of rules, regulations or musts is one of the unique features of A. A. as a local group and as a worldwide fellowship. There are no by-laws that say a member has to attend a certain number of meetings within a given period.

Understandably, most groups have an unwritten tradition that any one who is still drinking and boisterous enough to disturb a meeting, may be asked to leave; the same person will be welcomed back at any time when he is not likely to disrupt a meeting. In fact, members of the group will do their best to help sober him up if he sincerely wants to stop drinking.

WHAT DOES MEMBERSHIP IN A. A. COST?

Membership in A. A. involves no financial obligations of any kind. The A. A. program of recovery from alcoholism is available to anyone who has an honest desire to stop drinking, whether he or she is flat broke or the possessor of millions.

Most local groups "pass the hat" at meetings to defray the cost of hiring a meeting place and other meeting expenses, including coffee, sandwiches, cakes or whatever else may be served. In a large majority of the groups, part of the money thus collected is voluntarily contributed to A. A.'s General Service Headquarters to help support A. A.'s national and international services. These group funds are used exclusively for services designed to help new and established groups and to spread the word of the A. A. recovery program to "the million alcoholics who still don't know."

The important consideration is that membership in A. A. is in no way contingent upon financial support of the fellowship. Many A. A. groups have, in fact, placed strict limitations on the amount that can be contributed by any member. A. A. is entirely self-supporting and no outside contributions are accepted.

WHO RUNS A. A.?

A. A. has no officers or executives who wield power or authority over the fellowship. There is no "government" in A. A. It is obvious, however, that even in an informal organization certain jobs have to be done. In the local group, for example, someone has to arrange for a suitable meeting place; meetings have to be scheduled and programmed; provision has to be made for serving the coffee and snacks which contribute so much to the informal comradeship of A. A. gatherings; many groups also consider it wise to assign to someone the responsibility of keeping in touch with the national and international development of A. A.

When a local group is first formed, self-appointed workers may take over responsibility for these tasks, acting informally as servants of the group. As soon as possible, however, these responsibilities are, by election, rotated to others in the group for limited periods of service. A typical A. A. group may have a secretary, a pro-

gram committee, a food committee, a treasurer and a delegate who represents the group at regional or area meetings. The usual period of service is six months. Newcomers who have a reasonable period of sobriety behind them are urged to take part in handling group responsibilities.

At the national and international levels, there are also specific jobs to be done. Literature has to be written, printed and distributed to groups and individuals who ask for it. Inquiries from both new and established groups have to be answered. Individual requests for information about A. A. and its program of recovery from alcoholism have to be filled. Assistance and information have to be provided for doctors, members of the clergy, businessmen and directors of institutions. Sound public relations must be established and maintained in dealing with press, radio, television, motion pictures and other communications media.

To provide for the sound growth of A. A. early members of the society, together with non-alcoholic friends, established a custodial board—The Alcoholic Foundation. The Foundation serves as the custodian of A. A. traditions and overall service and it assumes responsibility for the integrity and service standards of A. A.'s General Service Headquarters at New York.

The link between the more than 5,000 A. A. groups and the Foundation is the General Service Conference of A. A. The Conference, comprising approximately 75 delegates from A. A. areas, meets with Trustees of the Foundation and with Headquarters staff members in New York City for several days each year. The Conference is exclusively a consultative, service agency. It has no authority to regulate or govern the fellowship.

Thus the answer to "Who runs A. A.?" is that the society is a uniquely democratic movement, with no central government and only a minimum of formal organization.

IS A. A. A RELIGIOUS SOCIETY?

A. A. is not a religious society since it requires no definite religious belief as a condition of membership. Although it has been endorsed and approved by many religious leaders, it is not allied with any organization or sect. Included in its membership are Catholics, Protestants, Jews and even a sprinkling of those who still consider themselves atheists or agnostics.

The A. A. program of recovery from alcoholism is undeniably based on acceptance of certain spiritual values. The individual member is free to interpret those values as he thinks best, or not to think about them at all, if he so elects.

Before he turned to A. A., the average alcoholic had already admitted that he could not control his drinking. Alcohol had, for him, become a power greater than himself, and it had been accepted in those terms. A. A. suggests that, to achieve and maintain sobriety, the alcoholic needs to accept and depend upon another Power that he recognizes is greater than himself. Some alcoholics choose to consider the A. A. group itself as the Power greater than themselves, while others choose to accept still different concepts of this Power. But most A. A.'s adopt the concept of God, *as He may be understood by the individual himself.*

Some alcoholics, when they first turn to A. A. have definite reservations about accepting any concept of a Power greater than themselves. Experience shows that, if they will keep an open mind on the subject and keep coming to A. A. meetings,

they are not likely to have too difficult a time in working out an acceptable solution to this distinctly personal problem.

IS A. A. A TEMPERANCE MOVEMENT?

No; A. A. has no relation to temperance movements. A. A. "neither endorses nor opposes any causes." This phrase, from the widely-accepted outline of the purposes of the society, naturally applies to the question of so-called temperance movements. Once the alcoholic has become sober and is attempting to follow the A. A. recovery program, his attitude toward alcohol might be likened to the attitude of a hayfever sufferer toward goldenrod.

While many A. A.'s appreciate that alcohol may be all right for some people, they know it to be poison for them. The average A. A. has no desire to deprive any one of something which, properly handled, is a source of pleasure. He merely acknowledges that he, personally, cannot handle that particular commodity.

ARE THERE MANY WOMEN ALCOHOLICS IN A. A.?

The number of women who are finding help in A. A. for their drinking problem increases daily. It has been estimated that one out of five or six in an A. A. group is a woman. Like the men in the group, they represent every conceivable social background and pattern of drinking.

The general feeling seems to be that a woman alcoholic faces special problems. Because society tends to place women on a higher pedestal than men, some women may feel that a greater stigma is attached to their uncontrolled use of alcohol.

A. A. makes no distinctions of this type. Whatever her age, social standing, financial status or educational attainments, the woman alcoholic, like her male counterpart, can find understanding and help in A. A. Within the local group set-up, women A. A.'s play increasingly significant roles. They work with newcomers. They help to arrange and program meetings. They are an integral part of the entire fellowship.

ARE THERE MANY YOUNG PEOPLE IN A. A.?

One of the most heartening trends in the growth of A. A. is the fact that more and more young men and women are being attracted to the program *before* their problem drinking results in complete disaster. Now that the progressive nature of alcoholism is better appreciated, these young people recognize that, if one is an alcoholic, the best time to arrest the illness is in its early stages.

In the first days of the movement, it was commonly thought that the only logical candidates for A. A. were those men and women who had lost their jobs, had hit Skid Row, had completely disrupted their family life or had otherwise isolated themselves from normal social relationships over a period of years.

Today many of the young people turning to A. A. are in their twenties. A few are still in their teens. The majority are probably in their thirties and forties. Many of them still have jobs and families. Many have never been jailed or committed to institutions. But they have seen the handwriting on the wall. They recognize that they are alcoholics and they see no point in letting alcoholism run its inevitably disastrous course with them.

Their need for recovery is just as compelling as that of the older men

and women who had no opportunity to turn to A. A. in their youth. Once they are in A. A., the young people and the oldsters are rarely conscious of their age differentials. In A. A., both groups start a new life from the same milestone—their last drink.

HOW DOES A PERSON JOIN A. A.?

No one "joins" A. A. in the usual sense of the term. No application for membership has to be filled out (In fact, many groups do not even keep membership records.) There are no initiation fees, no dues, no assessments of any kind.

Most people become associated with A. A. simply by attending the meetings of a particular local group. Their introduction to A. A. may have come about in one of several ways. Having come to the point in their drinking where they sincerely wanted to stop, they may have gotten in touch with a local group voluntarily. Many groups have telephone listings; the addresses of others are available by writing to Alcoholics Anonymous, Post Office Box 459, Grand Central Annex, New York 17, New York.

Others may have been guided to a local A. A. group by a friend, relative, doctor or spiritual advisor.

Usually, a newcomer to A. A. has an opportunity to talk to one or more local members before he attends his first meeting. He has an opportunity to learn how A. A. has helped these people. He gets facts about alcoholism and A. A. which help him determine whether or not he is honestly prepared to give up alcohol. The only requirement for membership is an honest desire to stop drinking.

There are no membership drives in A. A. If, after attending several meetings, the newcomer decides A. A. is not for him, no one will urge him to continue his association. It may be suggested that he keep "an open mind" on the subject, but no one in A. A. will try to make up his mind for him. The alcoholic himself is the only one who can tell whether or not he needs A. A.

WHAT IS AN "OPEN" MEETING?

An open meeting of A. A. is a group meeting that any member of the community, alcoholic or non-alcoholic, may attend. The only obligation incurred is that of not disclosing the names of A. A. members outside the meeting.

A typical open meeting will usually have a "leader" and other speakers. The leader opens and closes the meeting and introduces each speaker. With rare exceptions, the speakers at an open meeting are A. A. members. Each, in turn, may review some of his drinking experiences which led to his joining A. A. Or he may give *his* interpretation of the recovery program and suggest what his sobriety has meant to him. All views expressed are purely personal, since no one in A. A. ever speaks for anyone but himself.

Whenever possible, programs usually provide at least one woman speaker and an attempt is usually made to present speakers who represent different backgrounds or patterns of drinking.

Most open meetings conclude with a social period during which coffee, soft drinks, sandwiches are served.

WHAT IS A "CLOSED" MEETING?

A closed meeting is limited to members of the local A. A. group, or visiting members from other groups. The purpose of the closed meeting is to give members an opportunity to discuss particular phases of their alcoholic problem which can be understood best only by other alcoholics.

These meetings are usually con-

ducted with maximum informality and all members are encouraged to participate in the discussions. The closed meetings are of particular value to the newcomer since they give him an opportunity to ask questions which may be troubling him and to get the benefit of "older" members' experience with the recovery program.

MAY I BRING RELATIVES OR FRIENDS TO AN A. A. MEETING?

Any one interested in A. A., whether he is a member or not, is welcome at open meetings of A. A. groups. Newcomers, in particular, are invited to bring wives, husbands or friends to these meetings, since their understanding of the recovery program may be an important factor in helping the alcoholic to achieve and maintain sobriety. Many wives and husbands attend as frequently as their spouses and take an active part in the social activities of the local group.

(It will be recalled that "closed" meetings are traditionally limited to alcoholics.)

HOW OFTEN DO A. A. MEMBERS HAVE TO ATTEND MEETINGS?

Abraham Lincoln was once asked how long a man's legs should be. The classic answer was: "Long enough to reach the ground."

A. A. members don't *have* to attend any set number of meetings in a given period. It is purely a matter of individual preference and need. Most members arrange to attend at least one meeting a week. They feel that that is enough to satisfy their personal need for contact with the program through a local group. Others attend a meeting nearly every night, in areas where such opportunities are available. Still others may go for relatively long periods without meetings.

The friendly injunction, "Keep coming to meetings," so frequently heard by the newcomer, is based on the experience of the great majority of A. A.'s who find that the quality of their sobriety suffers when they stay away from meetings for too long. Many know from experience that if they do not come to meetings they may get drunk—and that if they are regular in attendance they seem to have no trouble staying sober.

Newcomers particularly seem to benefit from exposure to a relatively large number of meetings (or other A. A. contacts) during their first weeks and months in a group. By multiplying their opportunities to meet and hear other A. A.'s whose drinking experience parallels their own, they seem to be able to strengthen their own understanding of the program and what it can give them.

Nearly every alcoholic, at one time or another, has tried to stay sober "on his own." For most, the experience has not been particularly enjoyable—or successful. So long as attendance at meetings helps to insure the alcoholic's sobriety, and helps him to have fun at the same time, it seems to be eminently good sense to be guided by the experience of those who "keep coming to meetings."

DOES AN A. A. HAVE TO ATTEND MEETINGS FOR THE REST OF HIS LIFE?

Not necessarily, but—as one member suggested—"most of us want to, and some of us may need to."

Most alcoholics don't like to be told that they have to do anything for any extended period of time. At first glance, the prospect of having to attend A. A. meetings for all the years of the foreseeable future may

seem dismal indeed.

The answer, again, is that no one *has to* do anything in A. A. There is always a choice between doing and not doing a thing—including the crucial choice of whether or not to seek sobriety through A. A.

The primary reason an alcoholic has for attending meetings of his A. A. group is to help him stay sober *today*—not tomorrow or next week or ten years from now. Today, the immediate present, is the only period in his life that the A. A. can do anything about. He doesn't worry about tomorrow, or about "the rest of his life." The important thing for him is to maintain his sobriety now. He will take care of the future when it arrives.

So the A. A. who wants to do what he can to insure his sobriety today will probably keep going to meetings. But his attendance will always be on the basis of taking care of his immediate sobriety. As long as he approaches A. A. on this basis, no activity, including attendance at meetings, can ever resemble a long-term obligation.

HOW WILL I BE ABLE TO FIND THE TIME FOR A. A. MEETINGS, WORK WITH OTHER ALCOHOLICS AND OTHER A. A. ACTIVITIES?

The newcomer to A. A., who during his drinking days somehow managed to minimize the importance of time when there was alcohol to be consumed, is occasionally dismayed to learn that sobriety will make some demands on his time, too. If he is a typical alcoholic, he wants to make up "lost time" in a hurry. He wants to apply himself diligently to his job. He wants to indulge in the delights of a home life too long neglected. He may even be in a rush to devote himself to church or civic affairs. What else is sobriety for, he may ask, but to lead a full, normal life, great chunks of it at a time?

A. A., however, is not something that can be taken like a pill. It does suggest to him that the experience of those who have been successful in the recovery program is worth considering. Almost without exception, the men and women who find their sobriety most satisfying are those who attend meetings regularly, who never hesitate to work with other alcoholics who seek help, and who take more than a casual interest in the other activities of their groups. They are men and women who recall realistically and honestly the aimless hours spent in bars, the days lost from work, the decreased efficiency and the remorse that accompanied hangovers on the morning after.

Balanced against such memories as these, the few hours spent in underwriting and strengthening their sobriety add up to a small price indeed.

WHY A HOBBY IS USEFUL

THE reason a hobby is so useful in overcoming tension is that it puts to work those unused talents which might otherwise become restless, and it provides us with a form of activity in which there is no need whatever to strive for success. There is no compulsion, no fear of failure . . . We find it becomes easy to achieve, even though in other activities we have been barred from success by inadequacies or by fears in various forms, fears and their defeatist tensions. In this way, hobbies show us how to live and act without fear—an exhilarating experience which, through habit, becomes a habit of success in other activities.—Hal Falvey in "Ten Seconds That Will Change Your Life."

A SHORT STORY BY HORACE CHAMPION

How often, she wondered, had she wished she had no more feelings than Joe the Bartender. She knew she could be like other people if only they could . . .

As Bob was half-carried, half-dragged to the police car, a tear slipped down Mary's

THE big key rattled in the iron door and she heard the jailer's bored voice saying, "O.K., Mary, time's up. You can go now."

She arose slowly and made her way automatically to the desk where the matron was waiting with the three dollars and twenty-nine cents they had taken away from her thirty days before. Behind her the iron door clanged shut.

With the money clenched firmly in the pocket of her shabby coat she left the building and walked to the corner. People were walking by, talking, laughing, going somewhere.

She wondered what they were thinking. Could they tell? Nerves. Lousy nerves. Lousy people. Smug, self-satisfied little people. She wasn't hungry, but there was a funny, tight feeling in her stomach. A drink. That's what she needed—a drink. The thought repeated itself over and over, gathering speed, pounding out all other thoughts with blind insistence. A drink. She *must* have a drink.

Down the street a neon sign blinked "Tavern." A couple of beers would

TAKE OUT THE NERVE

cheek and she made a clumsy effort to wave goodbye with the empty whiskey bottle.

help. She made her way through the sea of smug faces. There was something warm and friendly about the sign.

THE bartender glanced up from the glass he was washing without expression.

Her mouth was set in a tight, determined line. "I want a beer, Joe," she said.

Joe shifted his cigar and placed the wet glass in the big freezer behind the counter to frost. "When did you get out?" he asked.

Her eyes were fixed on the rows of tall, frosted glasses and she could visualize the little flecks of ice sliding down the rim and floating across the amber-colored beer, the tiny bubbles racing from the bottom to greet them. A nice guy had once nicknamed her Amber. It was because of the color of her hair. "So soft, so lovely. It sparkles like fine cham. . . ." But that was long ago.

The ashes from Joe's cigar fell in a dead little heap on the bar before her. "I asked when you got out," he said in his detached, matter-of-fact manner. How often, she wondered, had she wished to God she had no more feelings than Joe did. If they could only operate and take out the nerve that causes all the trouble.

She sighed and spread a crumpled dollar bill on the bar. "Just give me a beer, Joe. I ain't in the mood for conversation."

He shrugged and filled one of the tall, frosted glasses.

She picked up the beer and the change and took a booth near the juke box in the corner. She spread out the change on the table. The beer tasted good. It had been a long time.

PRETTY soon the change was gone. She waved another dollar bill at Joe. Joe shook his head wearily but he brought her another beer. She smiled indulgently. "Play me something on the juke box, Joe," she said.

"What do you want to hear?"

"I don't care."

"We ain't got that. Maybe. . ."

"I didn't mean no special piece. Just something sentimental. Something soft and romantic." She handed him a quarter. "Play it all," she smiled.

Joe pressed the quarter back into her palm and jerked his head toward the juke box. A slim, bespeckled little man was studying the selections. His quarter dropped through the slot and plunked into the box. His long, nervous fingers hovered over the buttons indecisively. Finally, he made his selections, glanced at Mary, took one step toward her booth, hesitated, then walked quickly to the bar.

THE music was soft and sentimental and sad. It sounded like the little man looked. Mary held up her empty glass. When Joe filled a fresh one the little man said something to Joe, who laughed and shrugged his shoulders. The little man picked up the glass, tossed a coin on the bar, and brought the beer to her. Behind his silver-rimmed glasses Mary could see two very large, brown eyes. Maybe it was the specs, she thought, that made them look that way. They looked lonely, very lonely.

She took the beer and pushed a quarter at him.

"That's all right," he said, ignoring the quarter.

"O. K. Thanks." She looked down at her glass. The little flecks of ice were sliding down the side and disappearing into the cold, amber liquid. The little man's reflection stared at her from the surface.

"Well, sit down if you want to," she said. The tone was flat, without feeling, and it pleased her to realize

suddenly that she really felt a bit numb. You don't feel anything when you're numb. You get detached, like Joe. You can float away on a cloud to happy days in the past, or in the future. Wonderful, wonderful alcohol.

"Nice music," he said, seating himself in the far corner on the other side of the table.

No answer. She could remember music like that. Not the canned stuff, either. The real thing. Big name orchestra and the skylight roof garden. The evening gown studded with sequins. The way all the men stared at her. Soft music. Lovely shoulders. Yes, that's what he had said, "You've got the most beautiful shoulders, so white, so perfect."

"You looked lonely," the voice said. It snapped her out of her reverie. She looked up. There were the brown eyes again.

"I'm all right."

"Sure."

THE little man motioned for Joe to bring a couple of beers. He laid a five-dollar bill on the table. Mary wondered how many beers five dollars would buy. Enough probably. His ridiculously long fingers drew little channels through the moisture on the table top where the glasses had stood.

He cleared his throat, apparently to say something, then changed his mind. He looked embarrassed.

Joe set the beers on the table and counted out the change from the five-dollar bill. It looked like a lot of money to be lying on a table in a beer joint, Mary thought.

"You don't have to buy me beer," she said. "I can buy my own."

"I just wanted somebody to talk to, that's all," said the little man. "Beer's not so good when you're drinking by yourself." He drained about half of the glass. "Look," he said, "My name's Bob. Bob Trenchly. Work with a construction company. Least I did till this morning. Quit."

"No job?" She sympathized with him. She wasn't working now, either, she revealed. Restaurant she worked at went out of business. Just passing time until tomorrow. Then she'll go out and get another job.

"Waitress jobs are not hard to find," she said, so she wasn't worried.

Bob laughed. "Yeah, I can get a job anytime, too. I'm a riveter. Just couldn't stand the vibration this morning. Too much."

Mary laughed with him. The music had stopped.

"Well, what do you say we sort of celebrate, Mary. You know, no jobs, no work to go to in the morning."

Mary's eyes narrowed. "What do you mean?"

"Well, let's get a bottle. The real stuff, I mean, and go somewhere and drink it. Beer's too weak for what ails me. I got more money, too." He pulled out a well worn wallet. There was a picture of a girl movie star in the photo flap. This poor jerk's as bad off as I am, Mary thought. Nobody cares about him and he doesn't care about anybody. He fumbled for the lone bill. It was a five, too.

"Where'll we go? Joe won't let us sit in here and drink whiskey." Her voice sounded cautious, but there was an undercurrent of anticipation in it.

"I know a place down the street. We can sit in a booth and talk and drink and listen to the music. Friend of mine." He was already rising from his seat.

They left hand in hand. Joe shook his head as he watched them disappear into the passing crowd.

A FEW blocks away a bald, narrow-faced man with bulging eyes stood behind the bar of a dimly lit, poorly ventilated tavern and peered

suspiciously at the shabbily dressed couple entering the door.

Bob motioned him down to the end of the bar. Mary wandered over to the juke box.

"I want a bottle, Hugh," Bob whispered, slipping the five-spot across the bar.

The bald-headed guy seemed to be thinking. "When did you get out?" he asked in a manner that suggested somebody goofed by letting him out at all.

Bob ignored the attitude. "Listen," he said in a stage whisper, "Me and the lady ain't going to cause no trouble. We just want to go over in that corner booth and have a few drinks." He pushed the bill under the bartender's hand.

The bartender looked irritated. "You know I'm not supposed to sell whiskey to anybody. No license. Especially to you."

Bob's knuckles were white as he gripped the edge of the bar. His voice was low and determined. "I said I wanted a bottle, Hugh."

The bartender hesitated, then reached under the counter for the bottle. "Remember, no trouble," he warned. "Take a few drinks, then vamoose. I got enough troubles."

Bob tucked the bottle under his coat and motioned to Mary.

THE music in Hugh's place was more lively. So was the conversation. So were the drinks. The nickels and quarters plunked into the remote control box in their booth, and the juke box played on. Finally, there were no more quarters, or nickels, or drinks.

Bob yelled across the room. "Hugh! Come here, you old bald-headed monkey. C'mon 'n meet the prettish l'il gal in town!"

Hugh came over to the booth. He was wiping his hands on his apron, irritation spreading over his narrow face. "I told you not to cause no trouble in here," he said. "You'd better go." He looked at Mary. "And take your girl friend with you," he added.

Bob's face flushed. His eyebrows lowered until they were almost hidden behind the silver-rimmed specs. "Listen, Hugh," he growled, "Don't go high-horse with *me!* I've spent plenty of money in this crum joint. I'm a good customer, an' you know it."

Hugh held his hands up, the palms facing Bob. "Take it easy, bub," he said. "You're talking too loud. You've had enough. Now get along before you get in trouble. I don't want no trouble in here."

Bob got halfway to his feet, his legs coming in contact with the tabletop and rattling the empty glasses. The glasses reminded him he was in no position to argue. He smiled weakly.

"Listen, Hugh," he said, "Gimme a bottle on the cuff for a few days. I'm going back to work tomorrow. I'll . . . ."

Hugh shook his head, his mouth set in a firm line. "Can't do it. Never give whiskey on credit. Besides, you've had enough. Go on home or somewhere. I got other customers."

He turned to go. Bob grabbed the bartender by a shoulder as he turned and wheeled him around. Through clenched teeth he hissed, "You bald-headed, monkey-faced shylock! Gimme a bottle, or I'll. . . . ."

The bartender shook loose and shoved Bob back into the booth. The table gave way as Bob lost his balance and both he and the bottle went crashing to the floor, glasses skidding across the room.

Someone screamed for the cops, the bartender headed for the telephone, and Mary tried desperately to extricate herself from the wreckage. Somehow she found it impossible

to plant her feet firmly on the floor. Her knees were weak, terribly weak. And she was tired.

SITTING there on the floor she watched the cops drag Bob from under the table. As they hoisted him to his feet his eyes gazed stupidly from between half-closed lids, the silver-rimmed specs hung precariously from one ear, and his mouth was twisted into a one-sided grin. It's all a mistake, boys, he might have been thinking. I just slipped, that's all. I'll be all right. But his thick tongue and numb lips could not put thoughts into words. Two policemen half-carried, half-dragged him to the police car.

As the trio passed through the door, a tear slipped down Mary's cheek and she made a clumsy effort to wave goodbye with the empty whiskey bottle. Thus distracted she started to place the bottle to her lips for whatever drops might have remained when someone took the bottle from her hand. She looked up to see the expressionless face of a blue-coated policeman. He was saying, "Let's go," in that dull monotone that neither gives nor asks charity. Wouldn't it be nice, she thought, if I could be like that. If they could only find a way to take out the nerve that gets you so torn up inside. If they could only. . . .

BOB was in a limp heap on the seat, snoring peacefully when Mary's escort got in and sat between them. To see Bob slumped there, peaceful, contented, completely oblivious to the dirty deal life was handing them both, made Mary's face flush in anger. Bitterly she tried to strike him before she realized she was handcuffed to the policeman. She began to sob uncontrollably, "The gulper! The dirty, greedy, selfish gulper!" In a few minutes she was back where she had started the day.

The big key rattled in the iron door once more and she heard the jailer's bored voice saying, "That didn't take long, did it, Mary?"

And down the hall she heard another key rattling in another iron door, and a voice was saying, "Get out of that bunk, punk. I told you this guy would be needing it again before dark."

Behind her the iron door clanged shut.

IT'S BEEN SAID THAT

There are no hopeless situations; there are only men who have grown hopeless about them.

The world is a comedy to those that think, a tragedy to those that feel.

—Horace Walpole

To love for the sake of being loved is human, but to love for the sake of loving is angelic.

—Alphonse de LaMartine

Some people are like blotters—they soak it all in and get it all backwards.

A friend is a person with whom I may be sincere. Before him, I may think aloud.

—Ralph Waldo Emerson

All human wisdom is summed up in two words—wait and hope.

—Alexandre Dumas

What's Behind

THE concept of "craving" for alcohol has long needed to be clarified. It has been used to describe several different conditions: the inability of the addict to stop drinking, once he starts on a bout; the morning-after use of alcohol to relieve tremor, acute anxiety and other symptoms of hangover; the relapse into new drinking after days or even months of abstinence, daily excessive drinking; and others.

All these various alcoholic behaviors do suggest an element of craving. But in the opinion of a group of World Health Organization experts, "closer analysis reveals that different mechanisms are at work," and "a term such as 'craving,' with its every-day connotations, should not be used in the scientific literature" if confusion is to be avoided.

The WHO Expert Committees on Alcohol and on Mental Health, meeting in joint session at Geneva during the autumn of 1954, undertook to study and clarify the concepts of craving for alcohol. Although the seven members in their separate reports, approached the question from somewhat differing viewpoints, their conclusions about the distinction between the various events labeled as "craving" were not in conflict. Thus they were able to agree on a joint formulation.

How The Idea Started

The idea of craving in connection with alcoholism originated in part from the observed behavior of the addictive drinker toward the end of a bout when he is temporarily deprived of liquor. He then acts very much like the morphine addict whose drug supply has been cut off. A strong emotional crisis is evident and, in addition, certain physical

symptoms appear: coarse tremors, exaggerated reflexes, sometimes even convulsions. An electro-encephalogram at this time may show unusual brain waves. These so-called withdrawal symptoms have also been produced experimentally by H. Isbell and his associates (U. S. Public Health Service Hospital, Lexington, Ky.) when alcohol was withdrawn from men who for several weeks had been drinking about a bottle of whiskey daily.

But the misery of withdrawal symptoms, as the alcoholic discovers, can be alleviated or even prevented described as a "physical dependence on alcohol."

The individual, then, who has become physically dependent on alcohol through prolonged excessive drinking, may continue to drink in order to abort extremely painful physical symptoms. When this stage has been reached in the disease process of alcoholism, intoxication tends to become continuous and, thus, physically disastrous. Recovery from such a bout may require days or even weeks of hospital care. During this period, once the withdrawal state is passed, the patient will not

The Craving For Alcohol?

Is it due to physical deficiencies or to personality defects? Here's what the experts think.

by taking more alcohol. In this sense, then, he "craves" another drink. Physicians have found, however, that the demand for liquor stops if a suitable sedative other than alcohol is given. Hence it seems justified to think that the "craving" observed toward the end of a bout arises out of the need for relief from painful symptoms and is not a specific appetite for alcohol. This might be termed a craving for sedation. And what sedative is more convenient than alcohol, or more attractive to the alcoholic?

In the light of such findings concerning withdrawal symptoms and their treatment, the WHO Joint Committees concluded that "craving" in this context—to relieve the distressing symptoms when continuous heavy drinking is interrupted—is a misleading word. They agreed that this condition is more accurately show any of those signs of craving which the denial of a drink evoked a short time before. The imperative need for more alcohol apparently disappears. In due course he will return to normal life, with an interval of sobriety lasting weeks or even months.

The question now arises, what motivates the alcoholic to begin a new bout after he has sobered up and recovered from the earlier devastating experience? It is easy to theorize that an individual would never repeat this humiliating sequence of events unless some sort of uncontrollable desire or craving were ruling him. But in that case, what accounts for the hiatus between the two drinking episodes?

E. M. Jellinek (WHO Consultant on Alcoholism) underscored the distinction that must be drawn between two phenomena: (a) the events lead-

ing to the continuation of drinking during a bout, and (b) those that trigger the start of a fresh bout after an interval of sobriety. The failure to make this distinction, he feels, has been the source of much misunderstanding and conflict, as well as unwarranted claims of "cures" in alcoholism.

What Causes Relapse?

The relapse cannot be explained in terms of an acquired physical dependence on alcohol, any more than can the alcoholic's excessive drinking before any physical dependence could have developed. Some other mechanism is obviously involved in the phenomena of initial excessive drinking and relapse. Furthermore, whatever the explanation may be, this problem is far more fundamental to the whole subject of alcoholism as a disease than is the physical dependence which develops only after long-lasting drinking bouts. "Craving" in this more important sense has been attributed to a multitude of causes. Some investigators believe that it stems from an acquired or inherited metabolic defect—that it is of a physiological or biochemical nature. Within this school there are many shades of opinion. One group holds that the need for alcohol is based on nutritional deficits. Another group blames the apparent "craving" on some form of imbalance of the endocrines. Tension in alcoholics, which might lead to renewed drinking, has been reported to be associated with an incompletely identified chemical in the blood which is much reduced in amount after intake of alcohol.

L. D. MacLeod (Burden Neurological Institute, Bristol) in his memorandum reviewed the various physiological theories and pointed out fruitful directions for further research. The Expert Committee on Alcohol had earlier agreed that the evidence was not sufficiently convincing to justify acceptance of any particular physiological theory. But the Joint Committee at this time stated that "a physio-pathological condition (other than physical dependence) cannot be excluded as one of the factors which may lead to the resumption of drinking after days or weeks of abstinence."

In opposition to the physiological explanations of craving for alcohol, many investigators hold that a combination of cultural and psychological factors counts most in the origin of alcohol abuse. In the opinion of H. Isbell, the psychiatric-cultural theories offer the most satisfactory explanation of so-called craving at the present time. It has been demonstrated in many studies that a culture which frowns on heavy drinking produces proportionately fewer addictive drinkers than a group in which some drunkenness is tolerated. But since only a minority of individuals become alcoholics even in societies in which hard drinking is fashionable, cultural influences alone cannot be enough.

Psychological Factors

Given a cultural milieu in which immoderate drinking is condoned, perhaps the decisive factors in the explanation of alcoholism are the psychological ones. Alcohol is a substance which renders unpleasant situations more tolerable, which eases tensions and conflicts, which temporarily deadens anxieties. Once an individual has been introduced to this ready means of dissolving his troubles, it is a question of personality make-up whether this way of relief will have irresistible appeal. As a method, it competes with all other means of handling tension and anxiety. The majority of individuals develop non-alcoholic ways which are

more successful than excessive drinking. For the alcoholic, however, drinking sooner or later becomes the chief means of adaptation, and drunkenness the only defense against discomfort and conflict arising from inner pressures. Hence the sober intervals between bouts will tend over the years to become shorter and shorter.

Isbell pointed out also that no specific psychological traits are found in all individuals who develop drinking problems. Alcoholism is associated with schizophrenia, depressions, neuroses, and with the conditions now called character disorders and inadequate personality. "The only common denominator seems to be that some personality defect does exist, and that the patient drinks as one means of handling the symptoms arising from the personality disorder . . . . None-the-less, it is difficult not to conclude that, at the moment, the best formulation for the phenomenon of craving is a psychiatric one."

In this context, too, the word craving is felt to be unfortunate because of the pharmacological meaning it has acquired in relation to narcotic drug addiction. The Joint Committees, therefore, favored the phrase "psychological dependence on alcohol" to describe the mechanism which precipitates a fresh drinking bout or a relapse after a sober interlude. During the period of sobriety, psychological tensions gradually build up anew. The person who has already learned to rely on alcohol as the easiest way to deal with inner pressures may be able to withstand the tension for a time, resisting the temptation to get relief by "just a drink or two." But for how long a time? This will depend on the intensity of his psychological discomfort, on his psychic power of resistance, and on the strengths of the motives which can be mobilized, by means of treatment, against embarking on another try at drinking. The Joint Committees consider this psychological condition not a craving for alcohol but rather a sickly yearning for relief from accumulated tension. They point out, however, that mounting psychological tension is not the only cause of relapses in alcoholics. Social pressure to drink, even an accidental intake of alcohol, can trigger a new bout. They recognize, also, that some day a physical disorder of some sort may be discovered to play a role in this process.

The majority of alcoholics, thus, are seen as acquiring over a relatively long period of time a physical and psychological dependence on alcohol which leads to prolonged bouts and is responsible for relapses if treatment does not prevent them. The Joint Committees called attention, however, to another, much smaller group of alcoholics in whom the pathological desire for alcohol appears practically at the beginning of their drinking career. Their alcoholism, consequently develops rather quickly. In this group are certain types of psychopaths (implusive and volitionally weak personalities), as well as persons suffering, for instance, from epilepsy or mental disturbances following head injury.

A final point drawn in the joint formulation may help to explain why the disease process of alcoholism, the growing dependence on alcohol, tends to accelerate continuously: In all alcoholics, regardless of the original cause of their disorder, it is possible to observe a weakening of that part of the higher personality from which the control of primitive tendencies derives. "As a result, there appears a release of the primitive side of the personality," and the abnormal need for alcohol becomes increasingly dominant as the controlling forces weaken and ultimately fail.

VIRGINIA'S PROGRAM ON ALCOHOLISM

Their philosophy: care for the whole man — body, mind, emotions, spirit.

Reprinted by Permission of the Virginia Health Bulletin

THE present Virginia program of alcoholic study, treatment and rehabilitation resulted from legislation enacted by the 1949 session of the General Assembly. Just before that time, in 1947, the Assembly requested the Virginia Advisory Legislative Committee (VALC) to make a study of the alcohol problem in Virginia.

The VALC report, entitled "Inebriety in Virginia," revealed that a large number of inebriates were being admitted to State mental institutions. The report also showed that between 1943 and 1947, the number of persons committed to jail for drunkenness increased 83 per cent, while those arrested for drunken driving increased 119.3 per cent. The number of persons arrested for being drunk and disorderly increased 116.3 per cent. This report revealed a definite need for an attack on the alcohol problems and contributed to the passage of legislation which established the Division of Alcohol Studies and Rehabilitation within the State Department of Health.

The activities of the Division of Alcohol Studies and Rehabilitation were begun in October of 1948. In that month an out-patient service was opened at the Medical College of Virginia Hospital. In April of 1949 the Division's activities were expanded to include a 12-bed ward for in-patient treatment. The popular acceptance of this program is attested by the fact that at the end of the fiscal year June, 1949, a total of 129 patients were under treatment. In January of 1952 an out-patient clinic was set up at Roanoke for the convenience of residents of the western part of the State who found it inconvenient to travel as far as Richmond for treatment.

The DASR was set up to provide for: (1) a study of the problems of alcoholism; (2) the treatment and rehabilitation of persons addicted to the excessive use of alcoholic beverages; and (3) the promotion of preventive programs.

The legislation which set up the DASR provides that any Virginia resident who, through excessive use of alcohol, has become a burden to

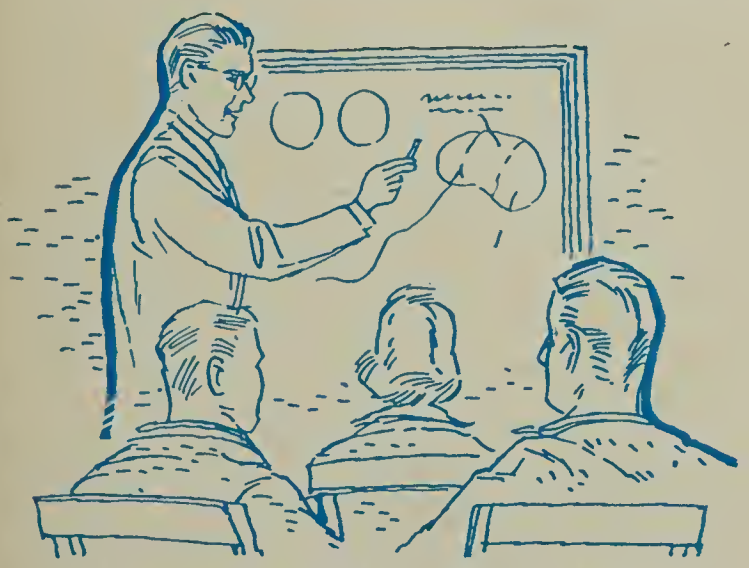
the public, may voluntarily request admission to the Division's treatment facilities.

Those admitted as in-patients may be acute alcoholics or patients in need of special medical diagnostic studies or treatment for which they must be hospitalized. While the larger majority of patients receive hospital care at the start of the treatment program, about 1 patient in 7 is treated entirely on an out-patient basis.

It is the philosophy of the Division that successful treatment of the alcoholic involves accepting him as a fellow man, with a humane and understanding attitude towards his problem—and that the alcoholic is an ill person who is well worth helping. Treatment must be directed toward the major aspects of the patient's life—physical, intellectual, emotional and spiritual. Attention to his physical ailments, personal problems, family difficulties, job troubles and religious needs may also be necessary.

Alcoholism is an insidious illness which probably develops over a long period. An alcoholic cannot be "cured" during a brief stay of a week or two in a hospital.

Patients are accepted on a voluntary basis and while they are advised to remain in the hospital for what is considered the appropriate period of time for initiation of treatment, they are not held in the hospital against their wishes. During the regular stay in the hospital, they are given appointments for necessary follow-up treatment in the out-patient clinic.



A physician explains to the patients the medical implications of alcoholism.

Each patient is given an examination soon after he is accepted for treatment. It is important to determine whether there are complaints which are causing an underlying illness that has been neglected. The patient may be worried about his heart, his stomach or more often about his nervousness, sleeplessness, or loss of appetite and weight. These worries or concerns, which are commonly attributable to alcoholism, must be considered if the patient is to make progress with his drinking problem. Occasionally, the examination will reveal other serious conditions which may influence the patient's desire to drink.

Specialized Treatment

Close cooperation has been established with the other medical specialties in the MCV Hospital and when diagnosis reveals a condition necessitating treatment which is not available in the DASR's Richmond facilities, arrangements are made for referral to the appropriate specialty for consultation and treatment. Many conditions may be treated while the patient is within the ward operated by the DASR. When surgical procedures are needed, patients are transferred to other portions of the hospital for this service; they are subsequently returned to the DASR ward.

Soon after the patient's admission either to the hospital or the out-patent clinic, a social worker is assigned to gather a complete social history if the physician in charge believes such a course is advisable. This history often provides information which the physician and other

staff members may use in understanding the patient's problem. If the physician desires, the social worker may be asked to maintain a close relationship with the patient throughout the entire course of his treatment. The services of a clinical psychologist are available when the physician in charge of the patient has reason to feel that these tests will help in making the diagnosis and in planning the patient's treatment.

Out-Patient Care

Experience has found that any course of treatment is headed for ultimate failure unless the patient continues to receive out-patient care faithfully. Out-patient treatments are scheduled normally about two weeks apart at the beginning and gradually extended to four to six weeks apart. This treatment is kept up for as long as a year or until there is evidence to show that the patient is on solid ground and has his alcohol problem under reasonable control.

More than 30 per cent of the patients are referred to the DASR by family physicians. Family physicians regard the Division as a resource which is available when highly specialized treatment is essential in patient management. In every instance of a referral from a physician, a detailed report of laboratory findings, diagnosis, and treatment procedures is sent back to him. This is important since many of the patients live long distances from the treatment center and when they begin to have difficulties with their drinking, they can go to their family physicians for treatment.

Patients are also accepted on referral from relatives and friends. Sometimes patients are self-referred. There are also referrals from the clergy. This latter group is limited, possibly because many ministers describe the DASR services to the alcoholic and advise him to decide *for himself* whether he sincerely desires to make application for treatment. Referrals often come directly through the health director of the county or city in which the patient resides; these patients are often discovered by the public health nurse.

A number of referrals from employers have resulted when an employer felt that he had an investment tied up in the training and experience of an employee, who was a chronic alcoholic. There have been several instances when employers have agreed to underwrite the cost of treatment in order to help a valuable employee attain sobriety.

The DASR cooperates with both public and private social agencies by accepting for treatment chronic alcoholics known to these agencies. Patients are accepted on recommendation from Police Courts as well as Juvenile and Domestic Relations Courts. However, those recommendations are carefully screened by the court in an effort to determine whether there is a sincere desire to attain sobriety. Many patients are accepted on the recommendation of Alcoholics Anonymous.

New Drugs Are Tried

Both the out-patient clinics and the in-patient ward have served to some extent as a laboratory where new drugs may be tried under conditions which serve to assess their value. New drugs which are being tried under out-patient conditions are those which do not serve as depressants but can reduce nervous tension and anxiety without becoming habit-forming.

As an in-patient procedure, many patients have been offered the opportunity to undergo treatment with Disulfiram. This course of treatment includes a thorough physical exami-

nation to determine if the patient may utilize this drug with safety. Lungs, heart, blood vessels, nerves, liver, and kidneys must meet certain standards to insure that the Disulfiram treatment may not have dangerous or possibly fatal effects. Because of the nature of body reactions to the drug when alcohol is ingested and because of the psychological factors involved in taking it, the prospective patient for this drug must voluntarily agree to undergo the treatment, to experience a controlled reaction when a small amount of alcohol is administered, and to cooperate in full course of related treatment. There must also be an agreement to make a sincere effort at personal and social readjustment.

Effects Of Disulfiram

Disulfiram alone in the system has not proven harmful, but mixed with alcohol it produces poisonous substances which react on the patient causing him to feel heated, to perspire, his heart pounds, his blood pressure drops, and he experiences difficulty in breathing. He may even become nauseated. However, these conditions soon pass, leaving no after effects. Upon discharge from the hospital, the patient recives a sufficient quantity of the Disulfiram to provide him a daily supply until the date of his follow-up out-patient appointment, when he receives an additional supply.

The Division carries on a program of alcohol research.

Persons accepted for care by the DASR are charged the actual cost of treatment. Those who are in a position to pay the hospital cost at the time of discharge are encouraged to do so. Those patients who have serious financial and job problems are assisted in finding employment. They are then given an opportunity to make payments on a monthly basis. Such payments vary in amount from $5.00 to $30.00 monthly. The Division's insistence that patients pay for their treatment is utilized as a therapeutic procedure whereby patients are taught to assume the responsibility for the management of their affairs. There is concrete evidence that the satisfaction patients get as a result of knowing that they have met their financial obligations is invaluable.

Limited Educational Program

Public awareness of the magnitude of the alcohol problem has developed slowly. During the first several years of the program, the Division has emphasized rehabilitation in order to establish concrete evidence that alcoholism is a remediable condition. The limited facilities of the service have made an intensive educational program impractical. Several educational activities have been developed. Members of the staff accept invitations to speak before both professional and lay groups.

Newspaper articles as well as scientific articles have been developed. Some of the scientific articles have appeared in such publications as *The American Medical Journal, The American Journal of Psychiatry, The Quarterly Journal of Alcohol Studies, Public Health Reports, and The Virginia Medical Monthly.* A brochure and several pamphlets have

been prepared and distributed to public schools in the State, physicians, social workers, and others interested in the alcohol program.

Possibly the most important educational activity is the annual symposium on the rehabilitation of alcoholics, sponsored by the DASR. National authorities have presented addresses at these meetings. These presentations have been printed.

There is increasing evidence that the role of the family physician in the management of the problems of the chronic alcoholic can be an important factor in helping to meet Virginia's needs. Inquiries and visits to the clinics by family physicians are encouraged.

Concurrently with the clinical study of alcoholic patients, a basic experimental research program has been inaugurated through the assistance of the professor of Pharmacology, the research professor of Biochemistry, and the research professor of Physiology at the Medical College of Virginia. Three full-time research assistants are conducting these studies.

Under study are (a) the effects of alcohol on cholesterol metabolism; (b) the effects of alcohol on carbohydrate and fat metabolism; (c) the possible detrimental effects of alcohol on the production of fatty livers; (d) basic experimental studies dealing with methods of treating acute alcoholic intoxication; (e) the effects of environment and various commonly used drugs on the pharmacological action of alcohol; and (f) the effects of alcohol on acethylcholine, glutamic acid, and adenosine triphosphate metabolism of brain slices. There is need for the development of evidence as to whether alcoholism as a disease manifests itself in biochemical or physiological alterations which may be estimated independently of ingestion of alcohol.

Program Pointers

(Continued from page 4)

prisoners. Dr. Kelly and Miss Lytle were pleased to note the lively participation in the discussion by the prisoner audience. Several women identified themselves as alcoholics, and requested information about existing resources for treatment and rehabilitation. We will follow the progress of this educational project with great interest. We hope that, at the least, our efforts will stimulate the formation of an active AA group at Womens Prison.

At the invitation of the Wilmington Community Council, Dr. Kelly and I recently journeyed to Wilmington, N. C. to make preliminary plans for staging an alcoholism institute in that city. It was decided to kick-off the education campaign with an open public meeting, tentatively scheduled for 8:00 p.m., February 13. Other meetings for professional and special interest groups will follow. As is customary, speaking duties will be handled largely by the NCARP staff. The Wilmington Community Council has pledged their enthusiastic support for the institute and we look forward to a productive effort there.

I think you can see that our schedule of activities for the New Year is beginning to shape up. But before we move into 1956, I would like to express our gratitude to all those who have contributed their interest and support to the successful operation of this Program during the past year. To all of our friends and supporters and to our former patients we send warm wishes for a New Year filled with happiness and contentment.

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
300 E. Northwood St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

Entered as Second-Class Matter at the Post Office, Raleigh, N. C., under the authority of the Act of August 24, 1912.

MARCH-APRIL, 1956

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

The N. C. Alcoholic Rehabilitation Center is a facility for the treatment of male and female problem drinkers who request admission. The clinic is located at Butner, N. C., and is operated by the North Carolina Alcoholic Rehabilitation Program under the N. C. Hospitals Board of Control. Admission to the Center is strictly voluntary. The cost of treatment is $75 for 28 days' stay.

Butner Treatment Methods

Treatment at the Center is by psychotherapy and consists of group discussions led by the clinical personnel, educational films, individual consultations with the doctors, vocational guidance, recreation, rest, proper food and prescribed medications. Butner is staffed by the Clinical Director, four other physicians, a chaplain, a psychologist, a social worker, a recreation director, an occupational therapist, and ten attendants.

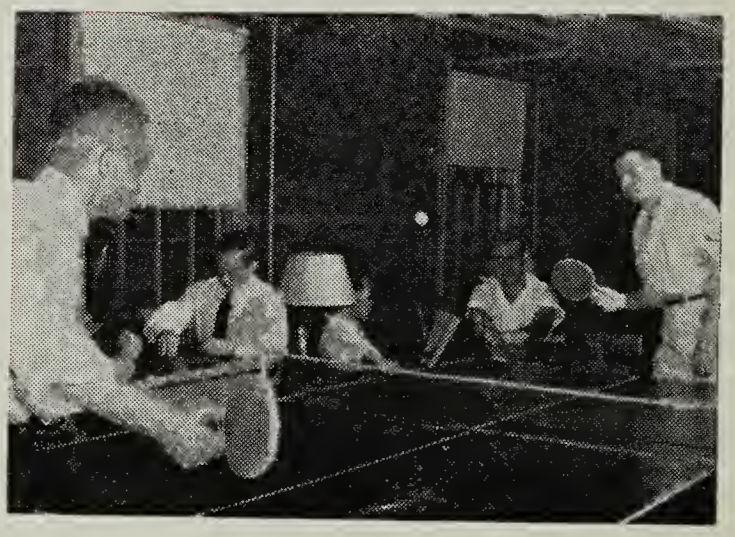
The Butner Patients

Patients must come to Butner of their own free will. No patients are accepted by court order. The patient who is sincere in wanting help and comes voluntarily to the Center stands a much better chance of a successful rehabilitation than the one who is pressured.

Entrance Requirements

1. Admission is by appointment only in response to written application to the Medical Superintendent, Butner, N. C., expressing voluntary desire for treatment.

2. A complete social history compiled by a trained social worker in the local Public Welfare Department or Family Service Agency, and a complete medical history, compiled by the patient's family physician are necessary.



3. A fee of $75, in cash or certified check, must be paid upon admission.

4. The signing, on admission, of a letter-statement, which requests voluntary admission.

It is especially important that patients applying for admission to the NCARP Treatment Center have a thorough medical examination and be in good physical condition at the time of their admission. There are no facilities provided at the Rehabilitation Center for the treatment of physical illnesses. Patients are expected to enter into the recreation program and to perform certain daily chores assigned to them. Patients with serious disabilities which would prevent their climbing steps are advised not to seek admission, inasmuch as sleeping quarters are on the second floor.

Admitting Hours

8 A.M. to 11 A.M. Monday through Friday
1 P.M. to 3 P.M. Monday through Friday
8 A.M. to 10 A.M. Saturday

Patients must be sober upon admission, and in good physical condition. No visitors are allowed.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA HOSPITALS BOARD OF CONTROL

S. K. PROCTOR
Executive Director

NORBERT L. KELLY, Ph.D.
Educational Director

DESMOND McNELIS, M.D.
Clinical Director

INVENTORY

VOLUME V NUMBER 6

MARCH-APRIL, 1956

RALEIGH, N. C.

An Educational Journal on Alcohol and Alcoholism. Published bi-monthly by the North Carolina Alcoholic Rehabilitation Program created within the State Hospitals Board of Control by Chapter 1206, 1949 General Session Laws authorizing the State Board of Health and the Department of Public Welfare to act in an advisory capacity. Offices, 15 West Jones St., Raleigh, North Carolina.

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Write: INVENTORY, 15 W. Jones Street, Raleigh, North Carolina.

ENTERED AS SECOND-CLASS MATTER AT THE POST OFFICE, RALEIGH, N. C.
UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912.

News From 'Round The World

A feature designed to help you keep posted on developments in the field of alcoholism.

MERATRAN—ANOTHER NEW DRUG

WINSTON-SALEM, N. C. Since alcoholism is not an illness **per se** but, rather, is a symptom of some underlying disorder, the effect of a new drug in a condition in which psychotherapy may play a large part is always difficult of evaluation. Nevertheless, preliminary results of a new drug used with psychotherapy on 40 alcoholic patients whose drinking sprees were triggered by feelings of depression shows promise. Richard C. Proctor, M.D., of the Department of Psychiatry and Neurology, Bowman Gray School of Medicine, and the Graylyn Hospital of Winston-Salem, used the new drug, Meratran (alpha-((2-piperidyl)) benzhydrol hydrochloride) on a group of alcoholic patients consisting of 25 men and 15 women. After the first year 18 of the 25 men have remained sober. Of the 7 who did not remain sober, 3 had only one alcoholic episode and 4 had two or more episodes. Among the 15 women 10 remained sober during the year, one had only one alcoholic episode, and 4 had two or more. Though Meratran is a stimulant and therefore resembles amphetamine in some of its action, it does not belong to the group of sympathomimetic drugs for it does not evoke the overactivity of the sympathetic nervous system characterized by dilated pupils, sweating, fast heart rate, and increased blood pressure. Some of the patients were given Meratran and instructed to take it when they felt themselves becoming depressed. The usual dosage was 2 mg. twice a day. Other patients were seen at regular intervals during the year and when depression seemed to be developing Meratran was prescribed in doses ranging from 2 to 8 mg. per day in divided doses. The medication was given for about a ten-day period. No patient had to take the medication more than six times during the 12-month period and the average was four. Dr. Proctor concludes that in some carefully selected cases of alcoholism where this is a symptom of depression Meratran may be a useful tool to use with other methods of treatment, particularly psychotherapy.

PUBLIC INSTITUTE HIGHLY SUCCESSFUL

WILMINGTON, N. C. What was considered to be the most successful public education institute yet attempted by the NCARP ended here on February 16. For ten speech-filled days and nights NCARP administrative and clinical personnel appeared before over 20 organized community groups and discussed the illness of alcoholism. With unprecedented cooperation from the daily newspapers and other communications media and the active sponsorship of the local medical society, an estimated 1,200 citizens flocked to the various meetings. At one open public meeting alone over 350 showed up and expressed considerable interest, asking many pertinent questions during an open discussion period. It is hoped that this community will organize its resources toward the development of a community program on alcoholism.

EDUCATION ON ALCOHOLISM FOR NURSES

NORTH CAROLINA. All nurses are invited to attend one of two Institutes on Alcoholism to be held exclusively for nurses at Raleigh and Charlotte early in May. Sponsored by the NCARP in cooperation with the nurses' associations, Raleigh's two-day institute will convene at the Carolina Hotel on May 1. The Charlotte institute will be held at Mercy Hospital May 3-4. Considerable interest has been shown by nurses and various hospitals throughout the State in this educational endeavor. Programs of the institutes will be identical. Speakers will include Desmond McNelis, M.D., Clinical Director of NCARP; John A. Ewing, M.D., Coordinator of Alcoholism Services at N. C. Memorial Hospital, Chapel Hill; Miss Grace M. Golder, Assistant Clinical Professor, Mental Health Nursing, Yale University Center of Nursing; Thomas T. Jones, M.D., prominent Durham physician who is chairman of the Alcoholism Sub-Committee of the State Medical Society; Miss Roberta Lytle, Psychiatric Social Work Consultant, NCARP; and Norbert L. Kelly, Ph.D., Educational Director, NCARP. No fees of any kind will be charged nurses who attend. They will, however, be expected to bear their own traveling expenses and board and room. Interested nurses from other states are also invited to attend one of the institutes.

PROFESSIONAL ASS'N ON ALCOHOLISM ORGANIZED

MASSACHUSETTS. The Professional Association on Alcoholism was organized recently and opened to doctors, nurses, hospital administrative staffs, enforcement, correctional and penal officials, social workers, occupational therapists, research workers, counselors, and others active in the treatment, rehabilitation, and prevention programs in the field of alcoholism. At its first meeting it was voted to appoint a research committee and communciate with officials of foundations for the purpose of studying the possibilities of raising funds for research under the auspices of the new association. Membership is not confined to the New England area. Inquiries concerning membership and programs of the new association should be addressed to Dr. David Landau, secretary-treasurer, 419 Boylston Street, Boston.

BREAKDOWN ON U.S. ALCOHOLIC POPULATION

CONNECTICUT. Mark Keller and Vera Efron of the Yale Center of Alcohol Studies have completed a new estimate (based on the generally accepted Jellinek formula) of the numbers of alcoholics in the United States as of 1953. They find about 4½ million alcoholics in the country as of that date. Of these, 3,800,000 are men and 700,000 are women. This means that the sex ratio among alcoholics is 11 men to 2 women. Although the new estimate is nearly one-fifth larger than the older one (1948), Keller and Efron believe that the new figure reflects improved diagnosis and steadily better reporting of basic medical information rather than an actual increase in the number of alcoholics. They calculated the rate of alcoholism to be 44 per thousand adults of both sexes. Among men alone the rate is 76 per thousand and among women, 13. There are great differences in the prevalence of alcoholism in the different states. California has a rate of 70 per thousand while the Idaho rate is less than 20. In North Carolina there are 52,150 men and 7,200 women alcoholics, according to these investigators, for a total of 59,350. The rate of alcoholism per thousand adults in N. C. is 25, the rate among men alone being 44 and among women, 6. Only one-fourth of these numbers are believed to have developed physical or mental symptoms as a result of their excessive drinking.

IT'S MY OPINION

THIS DEPARTMENT IS FOR THE USE OF AA MEMBERS WHO DESIRE TO EXPRESS IN 300 WORDS OR LESS THEIR IDEAS, OPINIONS, AND PERSONAL EXPERIENCES. ARTICLES FROM AA'S UP TO 2,000 WORDS WILL BE CONSIDERED FOR PUBLICATION ELSEWHERE IN INVENTORY.

I AM an alcoholic. When AA and I found each other nearly nine years ago, this knowledge came to me as somewhat of a shock. Because I had not lost my job, my wife, or my home, I felt that I was doing all right. My problem was merely that I was drinking the wrong kind of liquor, folks didn't understand me.

No one volunteered to explain AA to me. Perhaps no one cared enough or felt the result would be worth the effort. I don't know. I still do not understand the impluse which made me call the local office of the Fellowship. My makeup, even before I began to drink, was to always choose the easiest course—never to lay aside present pleasure for future profit. In my high school annual, under my graduation picture, was a little rhyme which went like this:

Life is a joke,
And all things show it.
I thought so once,
And now I know it.

It described me perfectly. My memory fails to register a single time when I chose to swim upstream instead of drift with the current.

This day, however, May 1, 1947, something happened. In reading our local veterans' weekly I had noticed a one-line advertisement—just the words "Alcoholics Anonymous" and a telephone number. To me, merely dialing that number on a drug store pay phone was one of the most memorable acts of my life. It brought me face to face with some startling facts, and a challenge. I felt, as so many others have, that no matter where the acceptance of these facts would lead me, or send me, it could only be better than where I was.

Even today, I am not sure about the word "alcoholic." I do not know why, or how, or when a person becomes a compulsive drinker. I know I felt in my heart I had to drink or die. I wanted to stop, but I was afraid to stop. Why, I do not know. Now, after my years with AA, I am happy in the knowledge that my daily victory over alcohol is part and parcel of my admission of defeat. For the first time in my life perhaps I had been honest with myself.

I know I can never again safely take even one drink. Which doesn't bother me, since this fact has brought me nothing but happiness and peace of mind. I know I must maintain my almost daily contact with AA, which is no burden, as I have learned to love the program and to spend a great share of my waking hours with it. I know I must help others as I was helped, but that brings nothing but pleasure. I know I must trust my problems to a power greater than myself, but nearly nine years have proved to me that here lies peace of mind.

Whether I am sober because I am happy, or whether I am happy because I am sober is another question without an answer. But who wants an answer?

—Austin M., Seattle, Wash.

Program Pointers

By S. K. Proctor

EXECUTIVE DIRECTOR

WE have been looking over the records of our educational activities during 1955 and have turned up some interesting figures. In no sense are they to be considered a yearly report, but merely an indication of what we are doing to educate the people of our State in the modern approach to alcohol problems. Here are some of the figures for what they are worth:

During the year 1955, members of our Raleigh organization alone had delivered a total of 133 talks and lectures on alcohol subjects to 25 different types of organizations. This represents an audience of approximately 8,000 persons reached by personal contact.

Motion pictures on personality development, alcohol, and alcoholism purchased by the ARP and placed in the film library of the State Board of Health were shown on 510 separate occasions during the year. Mr. Roger Whitley, director of the film library informs us that these films were booked by a variety of groups in all parts of the State.

A look at the circulation figures of the two radio series—The Lonesome Road and Anyone You Know—which we circulate from this office shows that a total of 109 of these 15 minute programs were aired by a number of the State's radio stations.

17,000 pieces of ARP literature were distributed upon request of individuals. This does not include the regular bi-monthly mailing of our publication, *Inventory*.

During the year the circulation of *Inventory* increased by 1,931 and stood at 17,667 for the November-December, 1955 issue. It is significant to note that this increase in circulation took place through direct written requests. We do not add anyone's name to the *Inventory* mailing list unless they personally request us to do so.

Summer Studies

A total of 160 public school teachers, both white and Negro, were enrolled in our five Summer Studies on Facts About Alcohol last year. We cannot estimate the number of young students who, through the influence of these teachers have received accurate, factual instruction about alcohol problems.

These statistics show that as far as volume is concerned, our educational efforts for 1955 enjoyed widespread attention. It is, of course, misleading to judge educational success by volume of output alone. The real test is the extent to which educational efforts change attitudes of the public toward alcohol problems. This is a very difficult thing to evaluate. But I think that we can see some obvious results of attitude change toward the problem in many areas of the life of this State. It is encouraging to note these changes. They assure us that at

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The Editor's Page

Inventory

Readers' Response

THANK you, dear reader! Your response to our plea for articles (Nov.-Dec., 1955 issue) was gratifying beyond our fondest hopes. As you read this issue we feel sure you will agree with us that these articles are the most stimulating we have yet published, and you wrote them! We wish we could publish all the fine articles you sent us in this issue, but we must budget our printing funds, so we will have to share the other articles with you in later issues.

If you happen to be the wife, husband, or other relative of an alcoholic you will surely not want to miss reading, "My Way Out" by a very understanding lady from Madison, Wisconsin. In a note accompanying her article, she wrote, "Usually, I don't feel that some parts of one's life need be known by others, but if what little I have said would prevent some other woman from making the same mistakes I did, I'd put my words into headlines." This is the best article of its type we have had the pleasure of reading.

You won't need a degree in psychology to understand the meaning of emotional conflict and its relation to alcoholism. Just read the article in this issue by Mr. Ralph W. Daniel, Executive Director, Michigan State Board of Alcoholism. Mr. Daniel paints word pictures in the manner of the Old Masters. No confusing abstractionism here; the meaning is clear, the style is refreshing, and he has something to say.

The 2,000 or more educators on our mailing list will get some valuable pointers on teaching about alcoholism from the article by Mr. Van S. Allen, Instructor, Hygiene Department, Bennett College. Mr. Allen is a graduate of the Yale Summer School of Alcohol Studies and is putting his knowledge to work in the classroom.

We are sorry to report that to our knowledge there is only one Al-Anon Family Group in North Carolina, and that group has just been organized at Greensboro. Al-Anon is for the wives, mothers, and other family members who live with alcoholics, recovered and otherwise. Its philosophy is based on the precept that the spouse of the alcoholic is also emotionally sick and needs the help

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

AL-ANON is for the family

BY GEORGE ADAMS

● *Al-Anon Family Groups: Twelve Steps to happiness for the non-alcoholic.*

IF you live with an alcoholic, take a look at yourself. How did you react the last time your alcoholic was on a toot? Did you adjust your halo and preach or scold? Or maybe you wept bitter tears of self pity and wailed, "How could you do this to me?"

Check your outlook on life. Are your nerves so ragged that you jump at your shadow, lie awake nights listening for your wandering alcoholic to stumble home? Have you pushed away all your friends, sloughed off outside interests and narrowed your life to a dogged 24-hour struggle with alcoholism? Have years of discouragement drained you of all hope for your alcoholic's recovery?

These are signs that alcoholism has taken its toll on you, the non-alcoholic member of the family. But don't give up hope. You may have to live with an alcoholic, but you don't have to continue to live with a defeated, frustrated outlook on life. You can get help for your problems through one of the unique fellowships called Al-Anon Family Groups, now springing up all over the country. Members are non-alcoholics like yourself whose lives have been warped by the excessive drinking of a loved one. To combat their common problems of fear, insecurity, lack of understanding, and topsy-turvy lives they live by a

simple program of emotional and spiritual growth which has led many non-alcoholics to happiness far beyond their fondest dreams. In Al-Anon you can benefit by the experience of others who have fought the same battle you now fight. They have found answers through a personal understanding of alcoholism and a willingness to learn how to cope with the confusion which it creates. So can you.

The first thing that Al-Anon will help you do is to learn the facts about alcoholism. Many who have lived closest to an alcoholic understand least about the nature of the illness. Family members blame themselves or feel that the alcoholic is drinking to rebel or hurt the wife or husband. Actually, science has shown us that the causes lie much deeper in the alcoholic's personality. He is a very sick person. His sickness is beyond the control of his will power. You cannot blame him once his drinking is out of control. Neither should you blame yourself.

Alcoholic Isn't Hopeless

By reading Al-Anon literature and talking with other members, you will learn these facts. And more important, in spite of your own hopelessness, you will see that few alcoholics are absolutely hopeless. Alcoholism can be checked. The thousands of ex-drunks in Alcoholics Anonymous are living proof of that. The road to recovery is often a long and trying one for you and your alcoholic. Scolding or preaching does little good. Something has to happen in the alcoholic's mental, spiritual, or physical makeup, or to all three, before he is willing to admit that he is sick and needs help. It is a tough situation for the non-alcoholic and calls for boundless patience and understanding. But, say other Al-Anoners who have been through it, a change in attitude on your part may hasten your alcoholic's decision to get help.

You're the key person to the Al-Anon philosophy. The Family Group puts the accent on doing something about yourself, instead of handing out advice on what to do *with* or *to* an alcoholic. It helps show you what you can do to make your life happier and more effective, thus boosting your alcoholic's chances for recovery.

Outgrowth Of AA

In mapping out a program of self-change for you, Al-Anon takes its cue from the proven recovery program of Alcoholics Anonymous. The Family Group idea is an outgrowth of Alcoholics Anonymous and is still closely linked with AA. Wives of pioneer AA's found their lives were still a mess even after their mates had followed the AA Program of recovery. Their answer: special meetings exclusively for families to discuss and attack their own problems. Word spread and AA Headquarters in New York was swamped with inquiries from troubled husbands and wives of alcoholics. As a result a clearing house was set up to answer the inquiries and dispense literature. In 1949 only fifty Family Groups were listed in the AA directory. Today, the clearing house is a separately incorporated unit, guiding the affairs of over 700 Family Groups. New ones are blossoming at the rate of one every three days.

How Al-Anon Works

How does the Family Group Program work? What are its basic principles? How can they be applied to your life?

Members of Family Groups base their lives squarely on the Twelve Steps of Alcoholics Anonymous. These steps were originally designed for alcoholics, but experience has

shown that they offer a solution for most of the everyday problems of non-alcoholic family members as well. Here are the Twelve Steps:

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

"Well, what's the excuse this time, stupid? Somebody twist your arm again?"

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us, and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Strike out the word, "alcoholics" in the last Step and substitute the word "others" and the Twelve Steps are completely applicable to Family Group members. Even the phrase, "We admitted we were powerless over alcohol," is appropriate for the partner of the alcoholic, too.

No Neat Prescription

If you are typical of other newcomers to the Group you may have reservations about the Twelve Steps. One Al-Anon wife said, "At first, the Twelve Steps seemed to be a neat prescription for perfection. I doubted that I could follow them to the letter. Anyway, I felt that I had always lived a pretty decent life."

But members with greater experience are on hand to reassure the doubters. The Twelve Steps are guides to a new way of living, they say, and not rigid requirements. You don't leap up the Steps two at a time and arrive breathlessly at the top. The idea is to take them slowly, one at a time. Keep them in mind and try to follow them and your thinking and actions will be guided gradually into constructive channels.

Look at Step One, for instance—the admission that you need help and cannot handle the job alone. If you take this step sincerely and really feel it emotionally, the sense of re-

lief from your burden of inadequacy and hopelessness is tremendous. You will then see that your responsibility to the alcoholic you love is to understand the nature of the illness and its effects on you. Realizing this, you can relax your steely grip on the problem and stop trying to browbeat or scold or pamper your alcoholic. When you accept help—from the Higher Power and from others—you make it easier for your alcoholic to do likewise.

Al-Anoners have found that all of the Twelve Steps are important but certain ones are essential to progress. Especially is this true of Steps Four and Ten—"Made a fearless moral inventory"—and "Continued to take personal inventory and when we were wrong promptly admitted it." These are clinched with Step Five—"Admitted to God, to ourselves, and to another person the exact nature of our wrongs."

Changing Old Attitudes

There is nothing new about this kind of non-morbid self analysis. Religion calls it confession. Psychiatry uses this technique as preparation for personality change. AA and Al-Anon Groups join religion and psychiatry in the opinion that it is the only sound way to change old unhealthy attitudes and develop new helpful attitudes in their place.

A personal inventory should include your assets as well as your liabilities. Otherwise, you would get a onesided picture of yourself. Everyone has an asset side to his personal ledger, and so do you. You who have lived with an alcoholic have tried to do your best. You have shown courage, loyalty, perseverance, and love as you understood these attributes. So don't sell yourself short.

Taking Inventory

After you've discovered your better side, you'll feel pretty good about yourself. But how about your defects? Haven't you detected flaws in your attitudes and behavior? When asked this question, the average newcomer to the Group says, "No, I don't think so. Living with an alcoholic is no picnic and I've done the best I could."

Others Will Help You

Here is where the experienced group members can help you. For each of them discovered that alcoholism brought out and accentuated their own personal defects. It is hard to face these because they may seem justified under the circumstances. Bottled up resentments and anger, insistence on running everything, overpossessiveness, and many other negative attitudes may seem to you to be natural results of living with an alcoholic. But if they are still present in your personality, they obstruct your alcoholic's recovery and block your own way to happiness and serenity. As you examine yourself more closely, with the help of a sympathetic Group member, you will root out more of these emotional liabilities. Dig them up courageously and discuss them with an understanding person and you will clear the air for future constructive action and thinking.

Don't let the inventory scare you

Hope is essential if the alcoholic and those who live with him and love him are to help him to regain his sense of dignity so that he can both give and receive love.

—Russell L. Dicks in the introduction to *How to Help an Alcoholic*

away from Al-Anon. It may be a difficult and at times painful task. One AA wife has written of her difficulties in taking inventory: "I received a tremendous shock," she says. "Many of the things I thought I did unselfishly to help my husband were, when I tracked them down, pure rationalizations to get my own way about something." But a personal inventory can be a big step forward for you and the alcoholic you want to help. Your associates in the Al-Anon Group will attest to that. They have faced the same shortcomings in themselves and stand ready to help you over the rough spots.

When you feel confident of your own progress and growth in Al-Anon, you will want to help others. When you assist other distraught relatives of alcoholics find a happier way of life you benefit as much as they. You shove your own difficulties aside as you become absorbed in the problems of others.

Practice of the Twelve Steps as a new way of life in the Al-Anon Family Group brings a wealth of new satisfactions to any partner or relative of an alcoholic. One of the tangible results noted by Group members is a happier home life, free from the bickerings and jealousies of former days. They are able to build stronger, better relationships with everyone—spouse, children, and associates. Free from the burden of shame and loneliness, warm mutually helpful friendships can be formed. These and other blessings can be yours in Al-Anon.

Perhaps you would like to join an Al-Anon Group. How do you go about it? The Al-Anon Family Group Headquarters (P. O. Box 1475, New York 17, N. Y.) can tell you if there is already a group in or near your community. Or you may be able to get the information by dialing the AA phone number.

There is no set pattern for Group meetings. A round table discussion may be the best way to handle a meeting if the group is small. Most Groups, no matter how informal, find it best to have a central theme for each session. Discussions of one of the Twelve Steps and its applications can make a stimulating meeting. Larger groups may follow the pattern of AA meetings and have two or three members relate their personal stories, followed by discussion. Outsiders—doctors, clergymen, social workers—may occasionally be invited in to discuss the family's role in alcoholism.

Meetings usually open with a moment of silence followed by a welcome to newcomers. Criticism of alcoholic partners and back fence "gossip" is barred. But there is plenty of time for free discussion and exchange of experiences. Meetings close with the Lord's Prayer by all who care to join in this tradition.

Headquarters Will Help

If there is not a Family Group near you, why not start one? Many Groups get started with two or three persons getting together in each other's homes. Group Headquarters will do everything they can to help you by providing literature and organizational details. Of course, you will want to be sure to solicit the aid of local AA members in your project. You may find there are other husbands and wives of alcoholics who will want to join you.

Don't be timid about starting a Family Group. Others have done it, and you can too. Be prepared for some ups and downs in your venture. Early enthusiasms of some members may dwindle. When problems arise write Group Headquarters for advice—and keep plugging. A new life awaits you. Good luck!

My Way Out

If someone you love has a drinking problem and all your efforts to help have failed, this true story by the wife of an alcoholic may be the most important story you will ever read.

BY EDNA R.

MADISON, WISCONSIN

IT sounds like the same old record. I am the wife of an alcoholic. Yes I am, but I had to learn to re-live my life, so that when my husband was drunk or sober I could still say, "I am the wife of an alcoholic," in a tone neither degrading nor glorifying.

Before my husband and I were married he told me he could never drink again and that he would kill himself before ever taking whiskey again. The word "alcoholic" rang a little bell somewhere in my mind, but being in love, I just accepted his word and thought no more about it. He never gave me any details of his drinking, because he honestly felt I would never have to live with it.

For six years after our marriage that man stayed sober—how I'll never know, because looking back, I wasn't easy to live with. I had two small children by a previous marriage (death—not divorce) and had been used to running the show. He was a good husband and step-father. All he wanted was a 50-50 deal in marriage, but I was too stubborn to see that. I accused him of being a nagger, a fault-finder, a Hitler and many more. Six years we battled over everything. If I had only known his background of drinking, his temperament and the reasons for being an alcoholic, things might have started differently. But that doesn't excuse me, not even now. I never wanted to discuss anything with him, and he started to drink again.

Return To Drinking

No one except other wives will know how frightened I was the first time I saw him drunk. The complete reversal of the man *I* had tried to dominate. He really was master when drinking. First weekend drinking, with me always shaming or telling him I could get along without him, so go on "get out." How that must have hurt, for a man raising two children not his own, bringing home good checks and his only real fault: he couldn't handle liquor. Down the ladder and then to the gutter. Every time I had him put in jail I really believed the shock would sober him for good. How foolish can one get?

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I could have gone on in my own smug way, thinking only of me, myself and I. But I finally realized he can be hurt the same as anyone else.

In and out of the state hospital, to start fresh again with high hopes. Then soon, like a rabbit, *I'd* run away for a day, maybe a week, never letting him know where I was. Then finally in desperation I'd call the police again.

We had two children of our own by now, which surely must have been his only reason then that he kept coming back to me.

It surely was the Lord's way, when one day a neighbor lady invited me to her home to meet some women who all had drinking problems in their homes. I remember so well stalling and hesitating, but finally told her that I only made a good listener. (Outside my home, that is.)

Well, I went and it was the longest meeting they'd had in a long time. For I talked all the time until coffee was ready. These were women who understood and didn't laugh or suggest divorce or condemn. When I walked into that room, I had friends again. (You lose all those you once had because you can't face them any more.) From that day on, almost three years ago, I've only missed three meetings and we meet once a week. I've been the Secretary for almost that length of time.

The drinker doesn't want to admit he's got a problem. The woman usually hates to admit *she's* the problem, or has one too. If you're worn out mentally and physically, tired from going around in circles, look in your phone book. Find an AA number to ask them if there is an "Al-Anon Family Group" nearby.

We have a program almost the same as AA and if you really want to help, make up *your* mind to try to practice this program. It strives for perfection and it is a goal none can reach. It's hard, believe me, but what a different person you get to be while trying. This way of life can become a habit, the same as the old. Learn to live one day at a time, yesterday's gone, tomorrow is not here yet so what's left? Just today!

Our favorite expression is "Keep your mouth shut." That's hard, gals, and it's real punishment, but many times when the men are tired, nervous, or sarcastic, one word from us, right or wrong, will set off that fuse. I don't mean be a door mat, but use good common sense. Each drinker is different and so there are exceptions as to how much you should take, how far you can go in helping him, but your decision to take it or leave it should be between you and God. No one else.

We've had sobriety in our home almost three years now. I never lose sight of the fact that the length of time doesn't determine when and if he will drink again. It could be tomorrow—maybe today. I'm not afraid any more. If he gets sick, I'll call the doctor, not a policeman, or if he needs care awhile, I'll help him get in a clinic or hospital, not an institution. I *know* I'm different to live with and so does he.

Actually I benefited by his drinking to the extent I could have gone on in my own smug way, thinking only of me, myself and I. I finally realized he's human too and can be hurt the same as anyone else. I'm trying now to make up to my children for the scenes in our home that I too was responsible for. I want them to have tolerance, patience, and most of all love for their father. I pray each day that God will help him stay sober that day and when he does, I don't forget to thank Him. Your life can be different, if *you* and you alone will make it be. My husband is a great guy and I pray some day he'll know just how swell I think he is. Look at your guy and think "But for the Grace of God there go I." Yes, I am the wife of an alcoholic.

WHAT CAUSES RELAPSES?

A psychiatrist discusses "The Three R's" of relapses—Resentments, Reservations, Remorse.

BY ISADORE TUERK, M.D.

SUPERINTENDENT,
SPRING GROVE STATE HOSPITAL
CATONSVILLE, MARYLAND

ONE of the most important and perplexing issues in the treatment of the alcoholic is the relapse. Slips may occur after a brief period of sobriety or after a prolonged one. They may reappear infrequently or in devastating rapidity. They may be relatively short in duration or protracted. In any case, they are a serious interruption of sobriety with highly disturbing consequences upon the self-esteem of the alcoholic earnestly trying to deal with his drinking problem, and with the creation of shattering insecurity in the family.

The physician's task in collaboration with the alcoholic is to try to understand the meaning of the relapse and to participate in an effective preventive program.

The slip can be a highly revealing experience and, although painful, can provide useful and valuable data leading to insight, improved sobriety, and personal adjustment.

Much has already appeared in literature about the psychology of the relapse. Attention has been directed to the immaturity of the alcoholic, to his low threshold of toler-

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ance for anxiety and frustration. It has been stated that relapses will continue to appear until the alcoholic has "hit bottom," that is, until his personal, social, and financial bankruptcy has become complete. Many a successful, sober alcoholic in retrospect feels that only when his suffering and revulsion at the unendurable plight precipitated by his uncontrolled drinking had reached such an endpoint, did he really stop drinking. It then became a matter of choosing between life and death, and if the choice was life, it became implacably associated with sobriety.

One such alcoholic repeatedly has stated at group sessions: "I know now I don't have to die a drunkard's death, and that is a good feeling."

The point of view involved in the need to hit bottom is a tragic, almost fatalistic one, that implies that a downhill course is inevitable, and the full cup of suffering and bankruptcy must be emptied before any significant change can be expected. This pessimistic attitude is modified in the concept that bottom can be high or low, that people can reach the point of emotional conviction about the necessity of sobriety after varying degrees of unhappy experience with their drinking.

Another important concept advanced by Alcoholics Anonymous and brilliantly analyzed by Tiebout is that relapses will occur until the alcoholic surrenders. Surrender implies yielding the egocentric, self-willed, arrogant attitude of the relapsing alcoholic who defiantly insists more or less consciously that he can drink, that he will drink, that he cannot be stopped, that he will not accept any authority other than his own impulses and infantile needs. Relapses are in this context the expression of the continued authority and power of "the little king, his majesty—the child" strongly entrenched in the alcoholic, brooking no interference, demanding complete autocracy, and dominating the life of the alcoholic with continued infantile behavior and drinking.

Simmel has called attention to the role of the archaic struggle with the fantasied mother in continued drinking, characterized by the pattern of "destroy and be destroyed." Each alcoholic bout then becomes a re-enactment of this emotional drive to effect one's own destruction and the destruction of the mother or her current substitute. Simmel also has clarified the strong dependency needs of the alcoholic, the wish to be taken care of, to become helpless in each relapse, nurtured and suckled back to health in an insatiably repetitive drama.

One is impressed after listening to the explanations offered by alcoholics for their relapses by the variety and ingenuity of their rationalizations and the sublety of the traps self-imposed. One such patient had heard it said many times in Alcoholics Anonymous, "It is the first drink that makes you drunk." In order to get

ABOUT THE AUTHOR

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Our guest author writes from a rich and varied clinical experience with emotionally disturbed patients, including alcoholics. He presently serves as Psychiatric Consultant to the Alcoholic Clinic at the University of Maryland Hospital, and is a past Director of the Baltimore County Alcoholic Clinic. Besides his many administrative and consultative duties, he serves as Instructor of Psychiatry at Johns Hopkins Medical School.

around this, he would go to a bar and order a drink of whiskey which he would not touch. He then ordered a second drink which he proceeded to consume. I told this to a group of alcoholics, and one of them made the remark that it probably was not long before he went back and drank that first drink.

Loneliness is frequently given as an explanation; the loss of the companionship of the drinking days, and the gradual gravitation back to the previous haunts, and after a shorter or longer period of abstinence, resumption of drinking through not wanting to be isolated or considered different.

Disappointments

Many have a feeling of serious disappointment with their sobriety. They feel that since they have decided to give up drinking, they should be rewarded by the world, and when their anticipation of the rich harvest of good things flowing their way is not fulfilled, relapses occur. It is difficult for them to abandon this expectation and face the inevitable problems of daily life with the conviction that sobriety in itself is worthwhile and is the foundation upon which they must build.

Others appear to get an unhealthy exhibitionistic satisfaction in presenting themselves in abject humiliation over and over again to the group as having slipped. They remain silent in group discussions until they have a relapse to discuss. Often the feeling of weakness, of ineffectiveness generated by relapses produces a pervading mood of helplessness in dealing with the urge to drink and the possibility of taking a more disciplined, constructive role.

Relapse can occur as a result of anxiety about the relationship between the alcoholic and his therapist. One patient who had been sober for several months had a brief relapse when she feared that getting well by staying sober threatened her with the loss of the therapist. It would mean being considered self-reliant and independent before she really felt she was, and this stirred up all the pain she had once had at the untimely death and loss of her beloved father.

The Three R's

It has been found useful in group discussions with alcoholics and in individual therapy to consider relapse in terms of "The Three R's," a concept borrowed from Alcoholics Anonymous philosophy. The Three R's are: Reservations, Resentments, and Remorse.

1) Reservations: The average alcoholic has grave difficulty in accepting the concept that an alcoholic cannot ever again drink in a socially acceptable, controlled way. Despite an apparent superficial acceptance of the principle that, with our present techniques of treatment, his only safe assured course of action is complete abstinence, tucked away in the back of his mind is the hope and expectation that some day he will again be able to drink—"This time it will be different; this time I will limit the number of my drinks." Reservations exist about the fact that it is just this incapacity to limit his drinking which is the characteristic symptom of the alcoholic's drinking problem. He cannot tolerate the idea that control exists only up to the point of taking the first drink. His hope is that if he remains sober for awhile, if he becomes strong enough physically, if he exerts will-power in not drinking for a period of time, then he should be able to drink in a pleasurable controlled manner once again. If he can test himself by having liquor around the home sufficiently long without touching it, this should be proof

enough of his strength in controlling his drinking.

The wisdom of Alcoholics Anonymous to the effect that the alcoholic is always one drink away from a drunken spree, no matter how long he has remained sober, is not really believed. With such reservations, relapses inevitably follow.

A patient taking Antabuse forgets to take the tablets for awhile, and thus sets the stage for another whirl at drinking. The alcoholic who has faithfully attended AA meetings stops going, and soon drinks again. Long before the actual drinking occurs, wet thinking appears. Dreams of drinking may occur. In all these instances the urge for a drink, and reservations about the inadvisability of taking a drink are manifest. Some alcoholics recognize that before taking a drink, they know they can't get away with it, but yet manage to dissociate that knowledge and effectively suppress it. It is clear that other powerful factors must be operative.

2) Resentments: Resentments play a potent role in initiating a drinking spree. Resentments appear on all sorts of pretexts. Offense is taken when someone is considerate or inconsiderate. It is almost as if there is a bottomless reservoir of anger, and an opportunity is sought to find an outlet for it. There is resentment at being an alcoholic. The incapacity to drink socially and the limitations implied in this are particularly resented. This feeling may be part of a general intolerance of any actual or implied limitations upon one's ability and freedom of action. There is the resentment of feeling exploited and dominated, and the feeling of being denied, of always giving and not getting. This can often be traced to a chronic feeling of being deprived by the mother. Finally in the alcoholic upheaval, the alcoholic gives himself what he feels he has been symbolically denied. Frustration of intractable

CHUCKLE FOR THE MONTH

DR. SMITH, a psychiatrist, complained about his hard work of listening to the patients all day long. He consulted an efficiency expert. The expert advised him to introduce into his practice a tape recording machine. The patients would talk into the machine and he could then listen to their talk *at his leisure time.*

Mr. Jones, who had the appointment to see Dr. Smith every day at 4 P.M., would come at the appointed hour, lie down on the couch and speak to the tape recorder. Dr. Smith would meanwhile go out to the corner drug store for a cup of coffee.

Weeks passed in this pleasant and efficient way. One afternoon Dr. Smith was just relaxing in the corner drug store with his cup of coffee, when—who came in?—Mr. Jones.

"What are you doing here?" asked Dr. Smith with grave concern. "Aren't you supposed to be lying on the couch and talking to the tape recorder?"

"Don't get upset, Doc," said Mr. Jones reassuringly. "Everything is under control. You see, I consulted an efficiency expert. He advised me to buy a tape recorder on which I could record all my troubles *at my leisure time.* And so—while we are both sitting here and drinking coffee, in your office *my* tape recorder is talking to *your* tape recorder."

—From *Am. Jour. of Psychotherapy*

dependency longings leads to resentment and drinking. One patient, shortly after a brief relapse, said, "For about a week before I drank, I took everything personally. I felt irritated by almost anything that happened. I felt paranoid. As a child I felt that I was the redheaded stepchild and that I was pushed around. In taking to drink, I was trying to get back at somebody. I should have been warned when I began to pick to pieces the sober members of AA. That harks back to my jealousy of my sisters as a child. I had to be first at everything. I probably had more attention than any of my brothers and sisters, yet it wasn't enough, or maybe it was too much. Deep down inside, I expected all the world to cater to me like my mother. Everybody should satisfy my every little whim. These feelings used to occur just before a menstrual period and I would drink. Having a period must have meant growing up, and I didn't want to grow up; then I wouldn't be able to cuddle up any more to mother."

Another implication of the resentment aspect of drinking is its use in power operations. To be opposed or disobeyed for one patient was intolerable. She used drinking as a cruel weapon to dominate her household and to wreak vengeance upon them whenever she was offended.

3) Remorse: Resentment leads to remorse. An alcoholic spree results in remorse which becomes so painful that more alcohol is needed to assuage the pain. There is self-pity for having wasted herself in drinking, for failing, for missed opportunities. Remorse originates in destructive wishes or actual alcoholic rampages. Remorse is linked with feelings of guilt of recent or childhood origin. Remorse becomes associated with self-depreciation. The feeling develops that because of the enormity of one's guilt, one is worthless. An effort to achieve self-esteem through sobriety is pointless.

These three issues—Reservations, Resentments, and Remorse—reinforce each other to produce relapse. Reference to these ideas, when propitious, in either group or individual therapy can be useful in promoting insight and in avoiding the fateful first drink. One alcoholic who has been sober for many years commented that feelings never got him drunk —that the only thing that got him drunk was alcohol. What he meant was that he had found it possible to cope with his feelings and his reservations in a more realistic and sober way and that, "If you are an alcoholic, you just don't drink." Only in this way can sobriety be maintained and the maximum satisfaction be derived from living.

HOW PSYCHOANALYSIS HELPS

PSYCHOANALYSIS is an attempt to help the patient to know himself, to become aware of the inner forces that guide his life, and to master those forces which are out of his conscious control. The analyst does not struggle with the patient but helps the patient to struggle constructively with himself, to resolve inner conflicts that have paralyzed him. Thus does the patient become the master of his own destiny, captain of his ship again, sailing towards the harbor, the set goal.

—Rudolph Ekstein, Ph. D. in the *Menninger Quar.*

AN ALCOHOLIC PERSONALITY ...

..WHEN DRUNK

TREATMENT AIMS TO IMPROVE HIS LABOR-MANAGEMENT RELATIONS SO THAT THE ALCOHOLIC CAN LIVE IN PEACE WITH HIMSELF AND HIS ENVIRONMENT.

..WHEN SOBER

FOR DETAILS READ THE ARTICLE, PLEASE

HC

DRUNK OR SOBER HE'S ALWAYS MIXED UP!

WHAT GOES ON INSIDE

You don't need to be a psychologist or to refer to a medical dictionary to understand this unique explanation of how personality conflict can lead to alcohol addiction.

BY RALPH W. DANIEL

EXECUTIVE DIRECTOR
MICHIGAN STATE BOARD OF ALCOHOLISM
LANSING, MICHIGAN

ALCOHOLISM can be called "a disease of the personality," or a disease of the "whole man," which includes physical, mental, emotional and spiritual aspects. It is difficult to understand alcoholism because it is difficult to understand the "whole man" which we speak of as the personality. This analogy has been prepared as an attempt to understand personality and alcohol and alcoholism.

A man's personality can be divided into two departments: The Labor Department and the Management Department. Both are important. Both have their work to do. Both must work together.

The Labor Department supplies power, activity and ambition. Many of the things that make life worth living are supplied by the Labor Department. Fun, excitement, good times, adventure, work and play are all divisions of man's Labor Department. The Labor Department puts steam in our boilers, electricity in our wires, gas in our engines and water in our dams. It puts the fire under the kettle and a sparkle in the eye. The Labor Department is the "Go! Go! Go!" department.

The function of the Management Department is quite different. It provides for the personality: judgement, wisdom, experience, control, and organization. It takes the power, the activity, and the ambitions of the Labor Department and uses them in the way that they will be the most productive. The Management Department says, "If you want fun, excitement, good times, adventure, work and play, here are some plans and procedures to use with your 'Do-it-yourself' urge." It points out the other experiences that a man has had in his drive for these things and reminds the man that some of these experiences were good and some were not.

It's The Regulator

The Management Department provides valves and pistons for the steam, motors and fuses for the electricity, brakes and steering gear for the engine, and turbines and flood gates for the dams. It puts a thermostat on the fire and a caution behind the sparkling eyes. It puts rules in the game and provides skills for

the "Go! Go! Go!"

A man's personality is healthy when the power of the Labor Department is channeled by the Management Department. A man gets the things he wants in a way that is approved by the people around him. He has good Labor-Management Relations. Problems arise in the "whole man" when Labor-Management Relationships are strained. A person becomes tense, irritable, nervous, belligerent, defiant and actually sick, because of internal Labor-Management conflict.

Conflicts Arise

Most people have experienced internal Labor-Management conflict where the Labor Department gets the upper hand. We stay out too late, drive too fast, spend too much, or work too hard. We say things that we later regret, and do things that we are sorry for when the Labor Department tries to "take over." The results may be mild or quite severe.

The other type of internal conflict is equally well known. The Management Department becomes a tyrant and represses the Labor Department with an iron fist. Symptoms of dictator tactics show up as feelings that we "are in a rut" or we "owe our souls" or we never have any fun, or we lose interest in life. We want to do things but just can't get started. This internal illness of the personality can be a mild illness or a fatal illness.

Labor May Strike

Throughout the centuries, tyrants have found that slave labor can be pushed beyond its limits. Life can become unbearable, and death a relief. With nothing to lose, oppressed people will revolt. This, too, can happen within a man's personality. The man who exercises too much control over himself may push his Labor Department to quit work and go on strike, or to revolt and try to overthrow the oppressor. The person who lives a "model" life for forty years and then commits a serious crime, may be the victim of a tyrannical Management Department and a revolting Labor Department. The person who is normally an "even tempered" person may be exhibiting the same problem when he suddenly "flies off the handle."

Alcohol in the body acts as a sedative that affects, first of all, the Management Department. Taking al-

NEUROTIC RELATIONSHIPS

THE content of the adult neurosis may include a dominating boss, business reverses, a nagging wife, overwork, or an alcoholic husband, but the structure, the particular form the neurosis assumes, is determined by the unresolved childhood conflicts. This means that the relationships of the adult neurotic are all child-parent relationships. The adult neurotic either seeks love in the same way and with the same dependent expectations as does the child in his relations with his parents, or he insists upon being the parent. None of the relationships of the neurotic are characterized by give-and-take and mutual respect as are those of the mature adult who, while striving for happiness, security, and love, not only satisfies himself, but satisfies also the strivings of the loved one.

—Lawrence A. Dombrose in *Mental Hygiene*
Published under the title, "Neurotic Conflict in Children"

cohol into the body is like putting sleeping powder in the boss's coffee. The part of the brain that houses the Management Department is the first to feel the sedative effect of alcohol.

Most of the people who use alcoholic beverages feel the need to mildly and temporarily slow down a slightly dominating Management Department. They relax a little better and they enjoy people a little more. It is an enjoyable feeling but not one of urgent necessity to the average drinker.

Unrealistic Goals

Even before the alcoholic takes his alcohol, he is different—inside his personality. He has a dominating Management Department and a Labor Department that won't take it lying down. He demands too much of himself. He sets his goals too high. He drives himself beyond his endurance and then criticizes himself because he fails. His Management Department and his Labor Department are engaged in an all-out war and each one demands unconditional surrender. It is a life and death struggle raging within and it can destroy his total personality.

The alcoholic, suffering from this Labor-Management war, has discovered a magic liquid that brings about a truce. To him, it is a life saving truce, and without it he would tear himself apart. It is his only hope of survival. He protects his supply of the magic liquid so that it is readily available in an emergency. He becomes addicted to it and "solves" all his problems with it. Unfortunately, for him the "solution" is temporary. His problem is intensified, and he is even worse off when the sedatives wear off. His Management Department starts nagging and criticizing and belittling and driving as soon as he sobers up, and for a while his Labor Department is subdued and meek and he is "a wonderful person when he is sober."

"I'm new around here. Where can I buy a pint?"

Helping The Alcoholic

Those who would help the alcoholic must assume the role of the labor mediator. They must work for a peaceful and cooperative relationship between his Labor and Management Departments. They must rebuild the whole man.

The condemnation, nagging and punishment that characterize our traditional reaction to the whole man that is addicted to alcohol, can never be effective. It is like slapping the wrist of a man who has known the lash. He has been nagged and punished and condemned by an oppressor far more powerful than any external force—his own Management Department.

This analogy was not intended as *The Answer* to understanding the alcoholic. It is an effort aimed at *an* answer for those who need to understand.

— CONNECTICUT —
pioneer program on alcoholism

Connecticut scored a "first" when it set up a state alcoholism commission back in 1945. Here is the story of the commission's growth and development during the ensuing ten years.

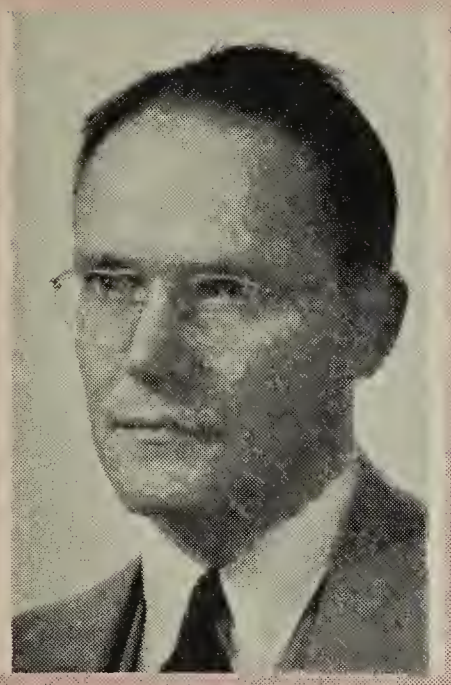
"IT must be emphasized that this is a new and frankly experimental service . . . . . Consequently the policies, organization and procedures are flexible, and subject to change. As psychiatric personnel becomes more available, as experience is gained, and as public attitudes gradually evolve toward a more rational, effective, and humane viewpoint, the work of the Connecticut Commission will present a clearer picture of what can be accomplished by a state commission in meeting the many problems of alcoholism."

With this cautious statement, Dr. Selden D. Bacon, Chairman, and Dr. Dudley Porter Miller, Executive Director, ten years ago expressed their early feelings towards the future plans of the newly created Board of Trustees of the State Fund for Inebriates established by action of the 1945 Connecticut Legislature. In 1947 the Legislature changed the agency's title to the Connecticut Commission on Alcoholism.

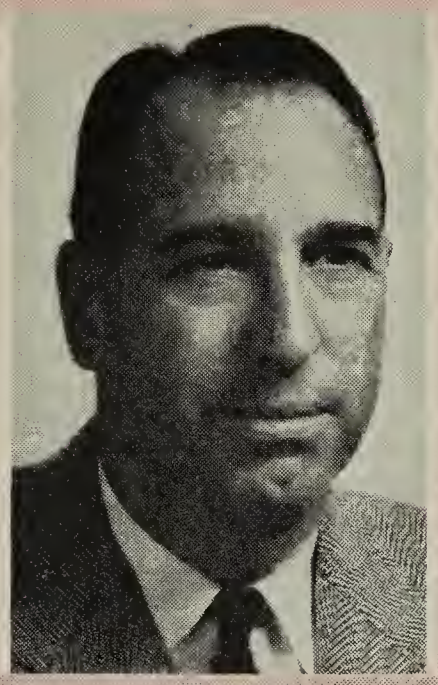
Before describing the organization, past activities, policies and future plans of the Commission, it would be appropriate to consider what appeared to be the major factors lying behind the establishment of this first program supported by public funds to approach alcoholism as an illness.

Aware Of The Problem

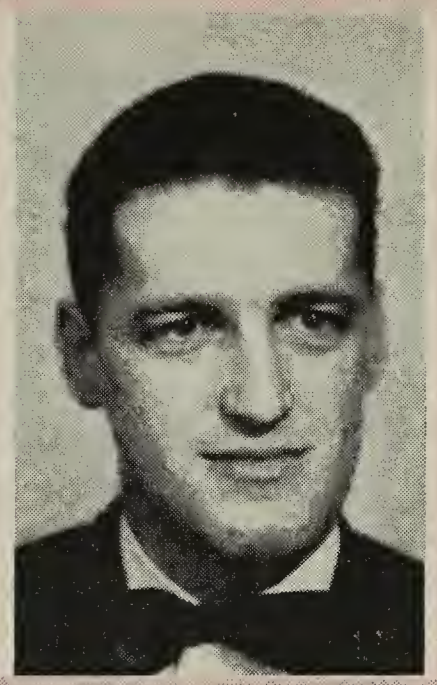
Connecticut had been mental hygiene conscious for a long time. The Mental Hygiene movement originated in Connecticut. Furthermore, Connecticut had been officially aware of the problem of inebriety since 1830 when the first report on the subject with recommendations for action was made to the legislature. The most ambitious program of the State was to be seen in the establishment of the State Farm for Inebriates which was closed in 1941 on grounds of inefficiency and expense. The loss of this facility was important in recreating recognition of the problem among police officials, judges, and penal administrators.



SELDEN D. BACON
COMMISSION CHAIRMAN



DUDLEY P. MILLER
EXEC. DIRECTOR



R. W. BRUNELL
ED. DIRECTOR

Of immediate importance in the war years was the matter of industrial manpower. As one of the most industrialized areas in the world, Connecticut was desperate for workers. Attention was finally called to the large jail population which was almost entirely made up of non-soldiers between 30 and 60 years of age of whom 70% were incarcerated because of drunkenness. Thousands of men were involved annually—a most frustrating situation for would-be employers in a period of labor shortage.

Between 1940 and 1943, two surveys were published on drunkenness: one on crime and inebriety in Hartford, the other on the extent and nature of drunkenness in the State, each issued by an official body. The recommendations in the latter study were almost wholly incorporated in the new law.

Of specific importance in influencing the form and techniques to be incorporated in the law were two developments, one national, and the other at that time primarily of local significance. These were first, the rise of interest in Alcoholics Anonymous and, second, the presence of the Yale group of researchers at New Haven in the field of alcohol and its problems. These groups suggested possible ways of meeting the problem, ways which were already in operation. The Yale group, aided by the Connecticut Prison Association, had established two clinics for alcoholics in the spring of 1944 and their work was even then achieving national reputation.

License Fees Hiked

Finally, although the evidence is not too clear on this point, representatives of the liquor industry expressed to the State government their willingness to accept higher licensing fees to pay for at least an experimental program to deal with the problems of alcoholism.

These would appear to be the major factors lying behind passage of the 1945 law. Many other in-

tangible processes were no doubt involved. When Connecticut established its alcoholism program ten years ago, it was the first such program in the nation. Since that time 37 other states having recognized the alcoholic as a public responsibility, have established programs of their own.

The statutory duties of the Commission are to study the problems of alcoholism, including methods and facilities available for the care, custody, detention, treatment, employment and rehabilitation of alcoholics; to promote meetings for the discussion of problems confronting clinics and agencies engaged in the treatment and rehabilitation of alcoholics; to disseminate information on the subject of alcoholism for the assistance and guidance of residents and courts of the state, and to accept for examination, diagnosis, guidance, or treatment any resident who requests such assistance.

Sources Of Funds

In order to meet these responsibilities, the Commission is authorized to make reasonable regulations for the care of patients and the management of its affairs; to purchase, rent or lease necessary buildings and equipment; to appoint an executive director and to employ such other assistants as are required. Nine percent of all moneys received by the Liquor Control Commission as fees for permits under the Liquor Control Act is assigned to a special fund for use by the Commission on Alcoholism in support of its work. Other income is derived from patient fees.

At its inception the Commission was charged by statute with carrying out a three-pronged attack on problems of alcoholism: (1) research, (2) treatment, and (3) education.

Continuing studies of the causes, the types and the various methods of treatment, and many related problems of alcoholism constitute the research phase. Research has been conducted in the evaluation of several drugs in the management of anxiety states, tremors, nutritional deficiencies and gastro-intestinal complaints among alcoholics. Other areas of alcoholism research have included blood sugar levels and sugar tolerance curves, the psychiatric implication in the use of "Antabuse," personality characteristics and changes, and evaluation of treatment techniques.

Out-Patient Clinics

During these ten years, five full-time out-patient clinics for the treatment of alcoholics have been established in Bridgeport, Hartford, New Haven, Stamford, and Waterbury. In 1950, the 50-bed Blue Hills Hospital was constructed and opened in Hartford. In this decade, 8,919 patients, including 1,387 women, have been admitted to the out-patient clinics and 4,958 individuals, of whom 732 were women, were admitted to the Blue Hills Hospital for assistance with their drinking problem. In addition, part-time treatment services were inaugurated at the State Farm for Women, the New Haven County Jail and Cedarcrest and Laurel Heights Tuberculosis Sanatoria.

Heart Of The Program

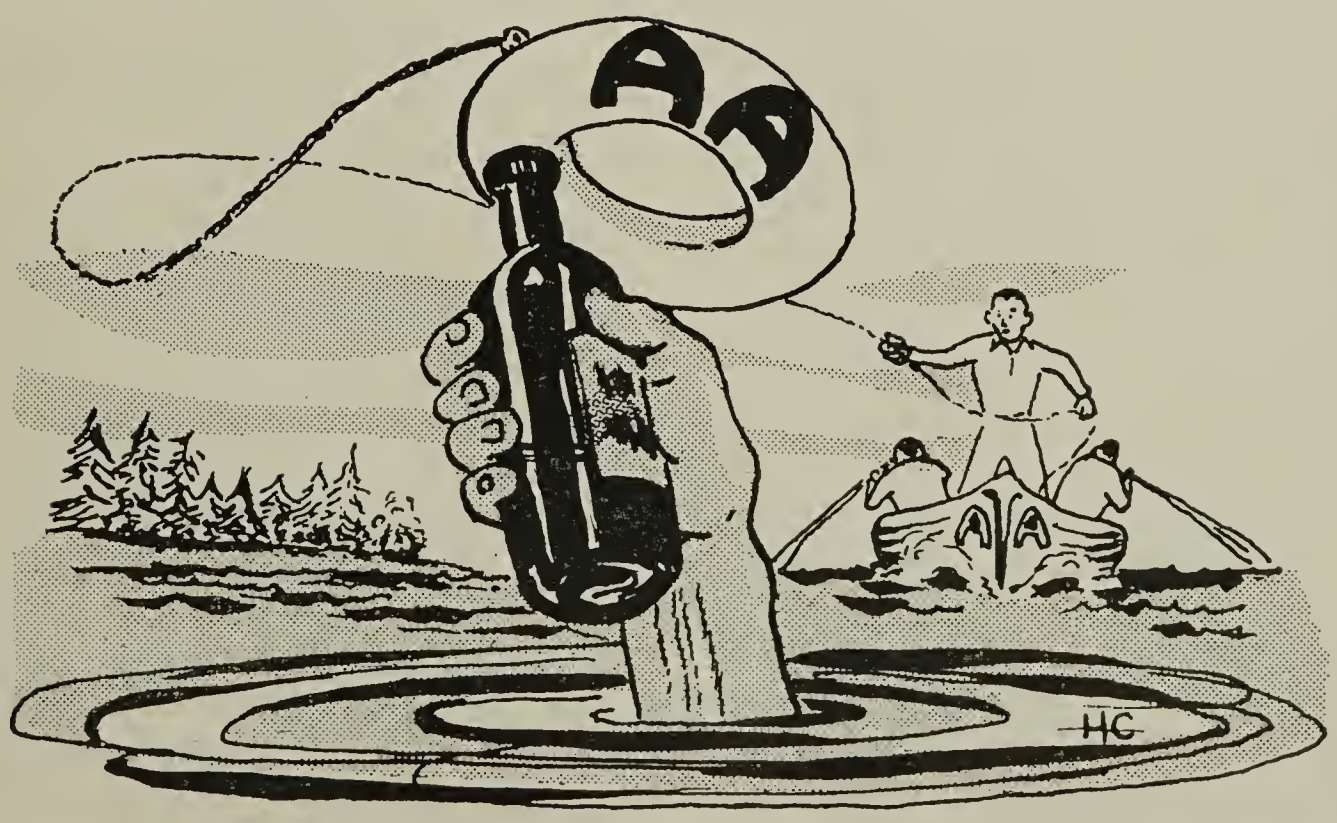
The out-patient clinic is acknowleged to be the heart of the Commission's program. The clinics are staffed with a psychiatrist, who directs the clinic's professional program, one or more psychiatric social workers, a consulting psychologist and necessary clerical personnel. At the out-patient clinics diagnosis and treatment are performed on a less expensive (both to patient and Commission) ambulatory basis through individual and group therapy. Out-patient care has the additional ad-

vantage of allowing the patient to recover in the same family, occupational, and social environment that provoked the alcoholic response. This is beneficial both to the therapist and patient in helping the patient adjust to environmental conflicts permanently without using alcohol. Being close to the public, the out-patient clinic has a great educational impact in terms of community understanding and prevention of alcoholism.

For those more acutely afflicted patients, Blue Hills Hospital offers limited diagnosis and controlled treatment of organic illnesses. Medical problems are studied from a point of view of their relationship to the patients' drinking behavior. Further psychiatric evaluation is undertaken to aid the out-patient clinic staff when the patient is discharged and referred to the out-patient clinic.

During his stay at Blue Hills, the patient is encouraged to take part in a variety of activities designed to give him more insight into his own problems, interests and abilities, and to develop attitudes and confidence in himself and his environment that will motivate him towards a sincere desire for recovery from addictive drinking and cooperation with the therapeutic program. Group sessions are held daily with extensive use of pertinent films and subsequent discussion of the underlying dynamics presented in the film relative to the patient's personal problems. Once each week an Alcoholics Anonymous meeting is conducted by a volunteer AA group allowing the patient to discuss and explore the AA program to recovery. All patients, as soon as declared physically able by the medical staff, are expected to contribute to the Hospital's kitchen, house-keeping, and maintenance requirements through assigned work schedules. Painting, weaving, metal work, wood work, ceramics, rug making, and other arts are under the direction of an occupational therapist and often disclose to a patient personal talents within himself that were previously unrecognized by him. Religious counseling and recreational facilities and programs provide still other approaches to effecting a recovery from uncontrolled drinking.

Admission to the Blue Hills Hospital is gained by referral by any



licensed physician in the State, or by any of the Commission's out-patient clinics. The cost at Blue Hills is $11.00 per day. While patients are asked to pay one week in advance, no eligible patient is refused admission because of inability to pay. The average length of stay at Blue Hills is about two weeks.

Concurrently with the development of treatment facilities and services, a program of educational activities on the nature, problems and treatment of alcoholism has been developed.

Members of the Commission's staff have held innumerable meetings with public groups for discussions on alcoholism as a major social and health problem, and on the Commission's program, services and facilities which are available to the public. These meetings have been held with a great variety of agencies and individuals including legislative committees, court and probation officers, police departments, jails, Alcoholics Anonymous, service clubs, PTA groups, school teachers and administrators, clergymen, church groups, social and welfare agencies, and secondary school and college students. In addition, many similar meetings have been held with representatives from 11 foreign countries and from 32 states in the United States who have come to Connecticut to see and discuss its program for alcoholics. The Commission's film library, exhibits, and educational pamphlets have been actively used. Ample use is made of the mass media through periodic news releases, radio talks and television productions. On one recent occasion, the Connecticut treatment program was presented on a nation-wide television hookup. For the seventh consecutive year, the Commission is providing fellowships for Connecticut residents engaged in pertinent vocational activities to attend the annual Yale Summer School of Alcohol Studies.

The Commission is presently engaged in planning a program to meet the chronic drunkenness offender problem. This program undertaken on a beginning, experimental pilot study basis will make possible (1) further study and experimentation on the size and treatability of the chronic drunkenness offender population; (2) verification of the modern theories of causation; and (3) an evaluation of what a state can do to realistically meet the problem on a larger basis. As part of the program, the Commission is currently setting up a "Half-Way House" facility that will allow extended treatment and a gradual social change and development from the protected, dependent institutional way of life of the jail to the competitive, sober, and independent way of a free society. It is hoped that the present activities and facilities of the Commission, the mental institutions, the tuberculosis sanatoria and the general hospitals, together with one or more "half-way" type facilities and possibly a self-sustaining commitment facility for non-treatables, will eventually meet the varying needs of all types of problem drinkers.

The fact that Connecticut has been privileged to pioneer this universal problem of alcoholism, that so many alcoholics have been restored to society as more useful, productive, happier, and self-sustaining citizens, and their families rebuilt and saved, is a continuing source of accomplishment and satisfaction to the Commission and its staff. With this feeling of accomplishment is a recognition that much has yet to be achieved in the prevention and treatment of alcoholism. Thus, the Connecticut Commission on Alcoholism looks at its past with pride, and to the future with much of the caution of ten years ago.

APPROACH TO ALCOHOL EDUCATION

Able direction, objective information, and open discussion are essential to alcohol education.

BY VAN S. ALLEN

INSTRUCTOR OF HYGIENE
BENNETT COLLEGE
GREENSBORO, N. C.

ACCORDING to the latest statistics having to do with the problems of alcoholism some 63,000,000 people in these united states partake of alcoholic beverages. Of this group approximately 4,500,000 are alcoholics and 1,000,000 of the latter figure are chronic alcoholics. For every eleven male alcoholics there are two female victims.

To the casual observer the above figures may have no significance. To the health educator these figures represent a challenge. This is particularly true when one considers the fact that alcoholism ranks high on the list of public health problems in America.

As a health educator the writer is very much concerned about what can be done concerning this problem at the college level. This concern is not without merit when considered in relationship to the following factors as these relate to alcoholism.

1. Our population is increasing rapidly.

2. The rate of alcoholism tends to be on the increase.

3. The unrest of the social climate of the world is of such a nature as to encourage men to seek relief through excessive indulgence in alcoholic beverages.

4. A goodly percentage of our automobile accidents, while not being attributed to alcoholism, can be traced to indiscriminate drinking on the part of drivers.

5. More children are being deprived of the guidance of both parents during the early years of their lives because both parents are "making the living." (These conditions, according to some of our leading psychologists and psychiatrists, often lead to frustrations that motivate individuals toward the drinking habit in later life.)

Considering the factors listed above, the question arises as to the responsibility of the health instructor to the students of the college where the problem of alcoholism is concerned.

The writer considers it the responsibility of the health educator of the

college, "to define, explain, and interpret alcoholism as it relates to the psychological, physiological, sociological, and religious aspects of living," with views for changing personal attitudes, meeting personal needs for information, and developing in persons the ability to help others who may need help with the problem of alcoholism.

Other Considerations

Several other considerations that must not be overlooked by the health educator are, the age levels of the students involved, the personal needs of these students, and the vocations elected by same students.

The age levels of students must be considered because by the time one reaches college age certain attitudes and opinions have already been formed. If these attitudes and opinions are erroneous ones the health educator must endeavor to help the students change them.

Some students will have personal problems in this area of living relating either to themselves or to members of their immediate families. The information that they receive should provide them with more of an understanding of their problems, thereby increasing the possibility of these individuals helping themselves and/or seeking professional help.

The vocation that a student plans to follow may have a far reaching effect on particular segments of the population. Consider, for examples, those persons interested in the fields of health, medicine, teaching, social work, etc. Because of the number and nature of contacts these persons have with people in pursuing their work it is obviously worthwhile for the health educator of the college to make certain that these persons are adequately exposed to all of the available information on alcoholism.

In developing the instructional procedures in alcohol education here at Bennett College the writer gave due consideration to each of the previously mentioned factors. The central core of our instructional emphasis has been in our advanced health classes in which we have our future elementary school teachers, some future high school teachers, students of the natural sciences, and a number of social science students.

The subject of alcoholism was first introduced to the class in the form of a questionnaire to which the students gave their reactions to a series of questions. These questions were worded so as to determine what the students knew and what they did not know about alcoholism.

The findings of the questionnaire were most interesting in that a num-

LEARNING TO LOVE

LEARNING to give love is like learning to use a new skill. At first we feel awkward, perhaps frightened. It is necessary to go slowly, to work in small, familiar, even trivial ways, and not to be discouraged if the response is slow in coming. We cannot change a pattern of years with a single gesture, an occasional word. But love freely given, without strings attached, without even a demand for thanks or gratitude, will sooner or later win love in return.

Arnold A. Hutschnecker, M. D. in *The Will To Live*

ber of students felt that alcoholism was strictly a moral problem. Some felt that it was a social problem. Few thought of it as being an illness. Many felt that there was no hope for the so-called drunkard, and several felt that religious deficiencies were responsible for the problem.

The questionnaire also revealed that students were interested in the causes, effects, preventions, and cures for alcoholism.

After careful consideration of the findings as revealed by the questionnaire the instructor prepared a unit on alcohol education treating its physiological, psychological, sociological, and religious aspects. Special attention was given to the items under each of these areas that the students exhibited a special interest in.

For classroom activities the instructor divided the class into four groups. Each group volunteered to uncover as much information about one of the four aspects of the alcohol problem as was available and to present same information to the class as a whole.

The instructor acted more or less in the capacity of a resource person and discussion leader.

The reaction of the group was one of enthusiasm. Many valuable questions were raised by the various study groups and these questions stimulated many heated and informative exchanges of information and ideas.

In the classes' effort to summarize their findings as to a possible approach to the solution of the problem of alcoholism and excessive drinking, it was concluded that more attention should be given to the living experiences of early childhood, with particular emphasis on the development of a well balanced personality. It was also the consensus of the group that the adult should strive for a life of balanced activities in which adequate consideration is given to work, recreation, love, religion and goals.

Program Pointers

(Continued from page 5)

least some of our education is hitting home, and it justifies our continued efforts in public education on as broad front as the limitations of budget and personnel permit.

When this issue reaches you, our staff will have completed its participation in the first community institute on alcoholism scheduled for this year. The institute was staged in Wilmington during the period, February 6-16. It opened with a public forum in which the audience was given an opportunity to question a panel of four men, including Dr. Kelly and myself. During the entire period of the institute, members of our staff spoke to over twenty civic and professional groups in and around Wilmington. One of the factors which insured the success of the open public forum was its sponsorship by two very influential forces in the community—the local newspaper publishers and the county medical society. It is a heartening sign that these two groups were willing to lend their support to a public meeting on alcohol problems. It is just another indication of the growing awareness among community leaders of the seriousness of these problems.

Our plans for holding two nurses' institutes on alcoholism early in May are complete. The first will be held at Raleigh on May 1-2, the second at Charlotte on May 3-4. So far as we know, this is the first time that an institute on alcoholism exclusively for nurses has been held in this part of the country.

The Editor's Page

(Continued from page 6)

of others in rearranging her or his own life toward the goal that the entire family can live together happily and harmoniously. Mr. George Adams, our assistant editor, tells you what he has learned about this new organization and explains how you can form a Family Group in your own community.

Continuing our series of articles about other state programs on alcoholism, we think you will enjoy reading the article about the first state program organized in this country to do something about the problem of alcoholism. Dudley Porter Miller, Executive Director of the Connecticut Commission on Alcoholism, and other members of his staff tell you how it started. They describe its development through the years, and consider plans for the future. As the pioneer state program on alcoholism, Connecticut has for more than ten years served as the light by which other state programs have steered their courses.

Please continue to send us your articles about alcoholism and its related subjects. Let us share the benefit of your experiences and knowledge with the other 18,000 people all over the world who receive this magazine. This may seem to be a small group, circulation-wise, but considering the many letters we receive telling us how *Inventory* helps them to help themselves or others to live happier lives, we know it is an interested group. You can help us to keep them interested and well-informed. Won't you write that article for us at the first opportunity?

ALCOHOLIC TREATMENT SERVICES

ARE PROVIDED BY THE FOLLOWING

MENTAL HYGIENE CLINICS

Competent Help Is Available At The Local Level

For an appointment the prospective patient or patient's relative should call or write to the nearest Clinic stating the problem for which help is requested.

Inability to pay is no barrier to receiving the services of Mental Hygiene Clinics. Fees are usually based on income, number of dependents, and ability to pay. It is a sign of good judgment for the person who has an alcoholic problem to seek help. All Clinics cooperate with the N. C. Alcoholic Rehabilitation Program and local agencies and persons interested in helping problem drinkers.

WRITE OR PHONE

Mental Hygiene Clinic
415 Halifax St.
RALEIGH, N. C.
Phone: 4-6484
Monday through Friday

Mental Hygiene Clinic
Room 415, City Hall
ASHEVILLE, N. C.
Phone: 3-8343
Monday through Friday

Mental Hygiene Clinic
300 E. Northwood St.
GREENSBORO, N. C.
Phone: 3-9426
Also at HIGH POINT
Phone: 8929
Monday through Friday

Alcoholism Clinic of the Psychiatric Out-Patient Service
N. C. Memorial Hospital
Chapel Hill, N. C.
Phone 9031

Mental Hygiene Clinic
1618 Elizabeth Avenue
CHARLOTTE, N. C.
Phone: 3-5441 & 3-5442
Monday through Friday

Forsyth County Program On Alcoholism
7th & Woodland Streets
WINSTON-SALEM, N. C.
Phone: 3-2471, Ext. 29
Monday through Friday

Graylyn Hospital
WINSTON-SALEM, N. C.
Phone: 3-7391
FRIDAY ONLY. This is purely a Clinic for alcoholics and their families. Out-patient mental hygiene clinic is located at Baptist Hospital, Winston-Salem.

Toward helping patients to re-establish satisfactory social relations all Clinics make their services available to wives, husbands, or other close relatives of patients.

ARP EDUCATION AND INFORMATION SERVICES

INVENTORY—bimonthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from State Health Department.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—ARP family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

The Lonesome Road—eight sets of eight 15-minute radio narratives dramatizing the way of the alcoholic, for use on local stations.

Anyone You Know?—radio drama of the steps to alcoholism, to voluntary treatment, to rehabilitation, in 15-minute records.

ARP Staff Speakers—members of the ARP's Raleigh and Butner staffs are available for speeches before civic and professional groups.

Library Kits—kits containing books and pamphlets on alcoholism. Available to libraries from N. C. Library Commission, State Library, Raleigh.

Book Loan Service—kit of reference works on alcohol and alcoholism, for high schools. Order from Education Director, 15 W. Jones St., Raleigh.

Consultant Service for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

N. C. Alcoholic Rehabilitation Program
15 W. Jones St.
Raleigh, N. C.

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